STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495109	A. BUILDING _____ B. WING _____	C 08/07/2019

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THE LAURELS OF UNIVERSITY PARK	2420 PEMBERTON RD RICHMOND, VA 23233

(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) COMPLETE DATE
F658	Continued From page 192 html 6. The facility staff failed to follow professional standards of practice for the transcription of physician orders for the monitoring and administration of Coumadin (1), a high-risk medication to Resident #8. The facility staff failed to transcribe a physician directive to decrease Resident # 8's Coumadin from 6 mg (milligram) a day to 5mg every day, from "Anticoagulant Record" into an order in the EHR (electronic health record), and onto the MAR (medication administration record. Resident #8 received 6 mg of Coumadin at 1700 (5:00 p.m.) every day from 5/2 through 5/14/19 instead of the 5mg of Coumadin (1) ordered for 12 days. In addition, facility staff failed to transcribe the provider's directive for PT/INR monitoring from the Anticoagulant Record to Resident # 8's EHR (electronic health record) on multiple dates in June, July, August, and October 2018 and in January, February, March, May and June of 2019. Resident # 8 was admitted to the facility on 08/14/2015 and a readmission on 01/08/2019 with diagnoses that included but were not limited to: deep vein thrombosis (1), other specified disorders of veins and high cholesterol. Resident # 8's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 04/19/19, coded Resident # 8 as scoring a seven on the brief interview for mental status (BIMS) of a score of 0 - 15, seven - being severely impaired of cognition for making daily decisions. Section N "Medications" coded Resident # 8 as receiving an anticoagulant in the past seven days.	F658		

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F658	Continued From page 193 The comprehensive care plan for Resident # 8 dated 02/05/2019 documented, "Need. (Resident # 8) is at risk for abnormal bleeding/bruising R/T (related to): medication use. Anticoagulant. Hx (history) of GI (gastrointestinal) bleeding." Under "Interventions", it documented in part, "Administer medications as ordered. Observe for effectiveness and side effects, report abnormal findings to the physician. Date initiated: 02/05/2019, Obtain labs (laboratory tests) and diagnostics as ordered and report abnormal findings to the physician. Date initiated 02/05/2019." Resident #8's clinical record including physician orders, nurse practitioner notes, nurse notes, and the medication administration record (MAR) were reviewed. Resident #8's "Anticoagulant Record" (a flow sheet used by the facility for monitoring Coumadin that was maintained separately from the clinical record with physician directives documented by the nurses and or physician that were not signed by the doctor) was reviewed. The review revealed the following failure to transcribe physician directives from the anticoagulant record into the physician orders in the electronic medical record: A physician's telephone order dated 05/01/19 for Resident # 8 documented, "Coumadin Tablet 6MG (Warfarin Sodium). Give 6MG by mouth one time a day for anti-coagulant. Hold 05/01/2019 14:45 (2:45 p.m.) - 05/02/2019 14:44 (2:44 p.m.)." On 5/3/19 Resident #8's "Anticoagulant Record" documented, "Current Anticoagulant Drug Dose: Coumadin 6 mg held on 5/2/19, PT 24.9 INR 2.1" Under "Action Taken by Physician" it documented, " 5 mg QD [every day] re-check	F658		

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F658	Continued From page 194 5/10/19." A "Nurse Practitioner's Note" for Resident # 8 dated 5/03/19, signed by ASM (administrative staff member) # 7, nurse practitioner, at 5:10 p.m. documented in part, "A/P: Leg DVT - Stable. 5MG coumadin QD (every day) and check INR 5/10/19. Monitor closely." Review of the "Anticoagulant Record" failed to evidence results of a PT/INR for 05/10/19. The Date 5/10/19 was crossed out with a line on the Anticoagulant Record. A hand written notation was written beside the crossed out date 5/10/10, documented, "MD (medical doctor) aware NNO (no new order)." Review of the May 2019 eMAR revealed, "Coumadin Tablet 6 MG (Warfarin Sodium) Give 6 mg by mouth one time a day for anti-coagulant. Start Date- 01/11/2019 1700 (5:00 p.m.), -Hold Date- from 05/01/2019 1445 (4:45 p.m.) -05/02/2019 1444 (2:44 p.m.). This order was documented as discontinued on 5/15/19. Review of the eMAR revealed Resident #8 received 6 mg of Coumadin at 1700 (5:00 p.m.) every day from 5/2 through 5/14/19 instead of the 5mg of Coumadin ordered for a total of 12 days. On 5/15/19, the MAR documented a"5" for the dose of Coumadin 6mg per the eMAR a 5 indicates hold see nurses notes. Review of the EHR (electronic health record) failed to evidence a physician's order was transcribed for the reduction of Resident # 8's Coumadin to 5mg per the 5/3/19 physician directive on the "Anticoagulant Record". Resident # 8 received Coumadin 6 mg not 5 mg from 05/03/19 through 05/14/19 for a total of 12 days.	F658		

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F658	Continued From page 195 Review of the facility's "Anticoagulant Record" for Resident # 8 documented PT (2)/INR (3) checks under the heading of "Action Taken By Physician" on 06/28/18, 07/05/18, 07/13/18, 08/20/18, 08/27,18, 08/30/18, 10/11/18, 01/11/19, 01/31/19, 02/04/19, 03/25/19, 05/01/19, 05/02/19, 05/03/19 and on 06/25/19. Review of the physician order sheets and physician's telephone orders dated 06/28/18 through 06/25/19 failed to evidence the physician's directives from Resident # 8's anticoagulant record were transcribed to physician's orders for the dates listed above. [Note the facility did not have a policy for the use of the "Anticoagulant Record" at the time of the survey. A policy was not obtained until after the facility was made aware of the concerns]. On 8/5/19 at 2:30 p.m., an interview was conducted with ASM #1, ASM #2 and ASM #3. When asked if they were aware of the situation that was uncovered (regarding the ineffective process for the safe administration of Coumadin and monitoring), ASM #3 stated, "No. The nurses were not necessarily doing the process and they assumed the doctor was putting the orders in the system and the doctors assumed the nurses were putting the order in the EMR (electronic medical record)." On 8/5/19 at 3:44 p.m., an interview was conducted with RN #8. RN #8 was asked if physician's orders regarding Coumadin and PT/INRs should be written. RN #8 stated physician's orders to hold Coumadin, change a dose of Coumadin, and for the next PT/INR that is due should be written. When asked the facility process for ensuring the orders are written, RN #8 stated the anticoagulant records should be reviewed each morning.	F658		

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F658	Continued From page 196 On 8/6/19 at 7:53 a.m., an interview was conducted with ASM #7, the nurse practitioner for Resident # 8. ASM #7 was asked if the directives written in the "Action Taken By Physician" column on the anticoagulant records have the full weight of a physician's order. ASM #7 stated, "Yes." ASM #7 was asked if nurses are expected to take the information documented in the "Action Taken By Physician" column and enter that information onto a physician's order written into the computer system. ASM #7 the nurses take that information and enter orders into the computer system for medication changes but as far as how the orders are entered into the system would be a question to ask the assistant director of nursing. ASM #7 was asked if she signs off on the directives the nurses write on the anticoagulant records. ASM #7 stated she does not sign the directives but she thought most of the time, the nurses take the directives and enter them as orders into the computer system. ASM #7 stated if the directives are entered into the computer system, then they will be entered as orders under her name and the orders will display for her to sign. ASM #7 was asked if directives for the next due PT/INR documented in the anticoagulant records should be followed. ASM #7 stated, 'Yes." ASM #7 stated she did not know if PT/INR directives documented on the anticoagulant records are entered into the computer system as actual orders or if the nurses use the directives in the anticoagulant record as written orders. On 08/06/19 at 11:15 a.m., an interview was conducted with RN (registered nurse) # 8, assistant director of nursing/unit manager regarding the transcription of the physician's	F658		

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F658	Continued From page 197 directive from the anticoagulant record to Resident # 8's EHR (electronic health record). RN # 8 stated, "There should be a physician's order to recheck the PT/INR. If the dose is changed, if a recheck is requested and if the medication is held there should be an order." When informed of the dates for PT/INRs on the "Anticoagulant Record" for Resident # 8 listed above, RN # 8 stated she would check progress notes. On 08/06/19 at 3:15 a.m., RN # 8 stated that she was unable to find physician's orders for the PT/INRs and that the orders were not transcribed into Resident # 8's electronic record. According to "Fundamentals of Nursing-Lippincott, Williams and Wilkins 2007 page 169, "After you receive a written medication order, transcribe it onto a working document approved by your health care facility...read the order carefully, concentrate on copying it correctly, check it when you're finished." On 08/05/19 at 5:10 p.m., ASM (administrative staff member) #1, administrator, ASM # 2, regional clinical coordinator and ASM #3 (director of nursing) were made aware of the above concern. No further information was presented prior to exit. References: (1) Deep vein thrombosis: This information was obtained from the website: https://medlineplus.gov/ency/article/000156.htm. (2) PT (Prothrombin): This information was obtained from the website: https://medlineplus.gov/ency/article/003652.htm.	F658		

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F658	Continued From page 198 (3) International normalized ratio (INR) is the preferred test of choice for patients taking vitamin K antagonists (VKA). It can also be used to assess the risk of bleeding or the coagulation status of the patients. Patients taking oral anticoagulants are required to monitor INR to adjust the VKA doses because these vary between patients. The INR is derived from prothrombin time (PT) which is calculated as a ratio of the patient's PT to a control PT standardized for the potency of the thromboplastin reagent developed by the World Health Organization (WHO) using the following formula: This information was obtained from the website: https://www.ncbi.nlm.nih.gov/books/NBK507707/ . 7. The facility staff failed to transcribe the physician/NP (nurse practitioner) directive for PT/INR (1) monitoring from the anticoagulant record to Resident #116's EHR (electronic health record) on 6/5/19 for 6/8/19. (The "Anticoagulant Record" is a tracking flowsheet utilized by facility staff without a policy directing how the sheet should be used for Coumadin monitoring. The sheet includes the date, current anticoagulant drug and dose, PT/INR, name of the nurse who completed the PT/INR, the test strip lot number, quality control test for the machine used to test for the PT/INR, the date the physician was notified and action taken by the physician). Resident #116 was admitted to the facility on 6/4/19. Resident #116's diagnoses included but were not limited to muscle weakness and chronic embolism (blood clot) and thrombosis	F658		

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F658	Continued From page 199 lower extremity. Resident #116's most recent MDS (minimum data set), a 30 day Medicare assessment with an ARD (assessment reference date) of 7/2/19, coded the resident as being cognitively intact. Section N coded Resident #116 as having received an anticoagulant medication seven out of the last seven days. Resident #116's comprehensive care plan dated 6/14/19 documented, "(Name of Resident 116) is at risk for abnormal bleeding/bruising R/T (related to) Anticoagulant use...Obtain labs and diagnostics as ordered..." Review of Resident #116's anticoagulant record revealed documentation dated 6/5/19 that documented, "Current Anticoagulant Drug and Dose: last dose (Coumadin) (2) 5 mg (milligrams) was held 6/2, 3 & 4. PT: 31.9. INR: 2.7. Action Taken By Physician: restart (Coumadin) 3.5 mg QD (every day) re (check) (PT/INR) 6/8/17 (sic)..." Further review of Resident #116's clinical record revealed a physician's order dated 6/5/19 for Coumadin 3.5 mg (milligrams) in the evening but failed to reveal a transcribed physician's order in the EHR for a PT/INR on 6/8/19. On 7/31/19 at 2:36 p.m., an interview was conducted with ASM (administrative staff member) #5 (Resident #116's physician). ASM #5 was asked how orders for Coumadin changes and PT/INRs are communicated, ASM #5 stated those are written in the anticoagulant record and she does not write actual orders for those. On 8/1/19 at 8:46 a.m., an interview was conducted with RN (registered nurse) #1. RN	F658		

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F658	Continued From page 200 #1 was asked if physician/NP directives for PT/INRs from the anticoagulant records are transcribed into physician's orders in the EHR. RN #1 stated she would put an order into the computer for a Coumadin dose change but she thought orders for PT/INRs are not written and are only documented in the anticoagulant record. On 8/5/19 at 3:44 p.m., an interview was conducted with RN #8. RN #8 was asked if physician's orders regarding Coumadin and PT/INRs should be written. RN #8 stated physician's orders to hold Coumadin, change a dose of Coumadin, and for the next PT/INR that is due should be written. When asked the facility process for ensuring the orders are written, RN #8 stated the anticoagulant records should be reviewed each morning. On 8/6/19 at 7:53 a.m., an interview was conducted with ASM #7 (the nurse practitioner). ASM #7 stated there is a "Coumadin book" (containing anticoagulant records) on each unit in the facility and the books are checked each day Monday through Friday. ASM #7 was asked if the directives written in the "Action Taken By Physician" column on the anticoagulant records have the full weight of a physician's order. ASM #7 stated, "Yes." ASM #7 was asked if nurses are expected to take the information documented in the "Action Taken By Physician" column and enter that information onto a physician's order written into the computer system. ASM #7 the nurses take that information and enter orders into the computer system for medication changes but as far as how the orders are entered into the system would be a question to ask the assistant director of nursing.	F658		

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F658	Continued From page 201 ASM #7 was asked if she signs off on the directives the nurses write on the anticoagulant records. ASM #7 stated she does not sign the directives but she thought most of the time, the nurses take the directives and enter them as orders into the computer system. ASM #7 stated if the directives are entered into the computer system, then they will be entered as orders under her name and the orders will display for her to sign. When ASM #7 was asked if PT/INR directives documented on the anticoagulant records are entered into the computer system as actual orders ASM #7 stated she did not know. On 8/6/19 at 10:54 a.m., Resident #116's anticoagulant record was reviewed with LPN (licensed practical nurse) #1. LPN #1 was asked if nurses are supposed to transcribe physician/NP PT/INR directives from the anticoagulant record to physician's orders in the EHR. LPN #1 stated prior to the survey, nurses were not required to do so. On 8/6/19 at 11:25 a.m., ASM #1 (the administrator), ASM #2 (the regional clinical coordinator) and ASM #3 (the director of nursing) were made aware of the above concern. No further information was presented prior to exit. (1) "Prothrombin time (PT) is a blood test that measures the time it takes for the liquid portion (plasma) of your blood to clot." This information was obtained from the website: https://vsearch.nlm.nih.gov/vivisimo/cgi-bin/query-meta?v%3aproject=medlineplus&v%3asources=medlineplus-	F658		

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F658	Continued From page 202 20PT%20calculation%20of%20INR&2.No further information was provided prior to exit. (2) "Warfarin (Coumadin): This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a682277.html *"Warfarin (Coumadin) can cause major or fatal bleeding. Regularly monitor INR in all patients." This information was obtained from the reference: Nursing 2016 Drug Handbook (Wolters Kluwer, 2016, p.1495) Black Box Warning	F658		
F684 SS=D	Quality of Care CFR(s): 483.25 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review and clinical record review, it was determined that the facility staff failed to provide care and services in accordance with professional standards of practice and the comprehensive care plan for three of 72 residents in the survey sample, Residents #338, #8, and #189. The staff failed to administer Coumadin to Resident #338 as prescribed by the physician on 6/30/18, and failed to obtain physician ordered PT (prothrombin)/	F684	Ftag 684 Resident #338: The resident no longer resides in the facility. Resident # 8: No negative outcome occurred as a result of this practice. A stat PT/INR was ordered and a revised Coumadin log was initiated for the resident corresponding physician orders were transcribed into the EMR. Resident #189: No negative outcome occurred as a result of this practice. A stat PT/INR was ordered and a revised Coumadin log was initiated for the resident corresponding physician orders were transcribed into the EMR. Residents receiving Coumadin have the potential to be affected. The DON or designee will educate licensed	9/20/19

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F684	Continued From page 203 (international normalized ratio) laboratory tests for Resident #8 on 11/10/18 and Resident #189 on 4/12/19, 6/26/19 and 7/27/19. The findings include: 1. The facility staff failed to administer Coumadin (1) to Resident #338 as prescribed by the physician on 6/30/18. Resident #338 was admitted to the facility on 6/29/18. Resident #338's diagnoses included but were not limited to revision of left total knee removal, asthma and high blood pressure. Resident #338's most recent MDS (minimum data set) (prior to discharge), a 14 day Medicare assessment with an ARD (assessment reference date) of 7/13/18, coded the resident as being cognitively intact. Section N coded Resident #338 as having received an anticoagulant medication seven out of the last seven days. Review of Resident #338's clinical record revealed a physician's order dated 6/29/18 for Coumadin- 2 mg (milligrams) by mouth in the evening for DVT (deep vein thrombosis) (2) prophylaxis. Review of Resident #338's June 2018 eMAR (electronic medication administration record) failed to reveal Coumadin was administered to the resident on 6/30/18 (as evidenced by a blank space instead of a check mark and nurse's initials to indicate the medication was administered). Resident #338's baseline care plan (no date) documented "Anticoagulant- (a check mark beside) Observe S/S (signs or symptoms) of bleeding, report as indicated..." The baseline care plan failed to document information regarding Coumadin administration.	F684	nursing staff on the process for Coumadin management and transcription of orders into the EMR. The DON or designee will audit Coumadin logs and orders for residents receiving Coumadin for accuracy and completion. Nursing administration or designee will monitor Coumadin logs 5 days a week for 1 week, 3 days a week for 2 weeks, weekly for 4 weeks, and monthly for 3 months. Any variances will be corrected and additional education or counseling will be provided as needed Any concerns will be reported to the quality assurance committee monthly until resolved. Continued compliance will be monitored through the facility's quality assurance program. Additional education and monitoring will be initiated for any identified concerns. Completion Date: September 20, 2019	

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	495109	A. BUILDING _____ B. WING _____	C 08/07/2019

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F684	Continued From page 204 Resident #338's comprehensive care plan dated 7/11/18 documented, " BLEED101: At risk for abnormal bleeding R/T (related to) anticoagulant use...Interventions: Administer medications as ordered..." The nurse responsible for administering Coumadin to Resident #338 on 6/30/18 was not available for interview during the survey. On 8/5/19 at 3:44 p.m., an interview was conducted with RN (registered nurse) #8. RN #8 was asked how nurses evidence medication administration. RN #8 stated, "They verify the medication, pull the pills, sign off after the med (medication) is administered and click in the eMAR system." When asked what is meant if a medication is not signed off, RN #8 stated, "It was not administered unless there is another note somewhere." Review of nurses' notes dated 6/30/18 failed to reveal Coumadin was administered to Resident #338. On 8/6/19 at 11:25 a.m., ASM (administrative staff member) #1 (the administrator), ASM #2 (the regional clinical coordinator) and ASM #3 (the director of nursing) were made aware of the above concern. The facility policy titled, "MEDICATION ADMINISTRATION" documented, "All medications and treatments shall be initiated, administered, and/or discontinued in accordance with written physician orders...9. Administer the medication. 10. Initial the guest's Medication Administration Record (MAR) immediately following administration..." No further information was presented prior to	F684		

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F684	Continued From page 205 exit. (1) "Warfarin (Coumadin) is used to prevent blood clots from forming or growing larger in your blood and blood vessels. It is prescribed for people with certain types of irregular heartbeat, people with prosthetic (replacement or mechanical) heart valves, and people who have suffered a heart attack. Warfarin is also used to treat or prevent venous thrombosis (swelling and blood clot in a vein) and pulmonary embolism (a blood clot in the lung). Warfarin is in a class of medications called anticoagulants ('blood thinners'). It works by decreasing the clotting ability of the blood." This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a682277.html (2) "Deep vein thrombosis, or DVT, is a blood clot that forms in a vein deep in the body. Most deep vein clots occur in the lower leg or thigh. If the vein swells, the condition is called thrombophlebitis. A deep vein thrombosis can break loose and cause a serious problem in the lung, called a pulmonary embolism." This information was obtained from the website: https://vsearch.nlm.nih.gov/vivisimo/cgi-bin/query-meta?v%3Aproject=medlineplus&v%3Asources=medlineplus-bundle&query=dvt&_ga=2.137988019.2081124811.1565615930-1667741437.1550160688 2. The facility staff failed to follow physician order to obtain a laboratory test PT/INR (prothrombin time (1) / international normalized ratio) (2) for Resident #8 on 11/10/19.	F684		

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F684	Continued From page 206 08/14/2015 and a readmission on 01/08/2019 with diagnoses that included but were not limited to: deep vein thrombosis (3), other specified disorders of veins and high cholesterol. Resident # 8's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 04/19/19, coded Resident # 8 as scoring a seven on the brief interview for mental status (BIMS) of a score of 0 - 15, seven - being severely impaired of cognition for making daily decisions. Section N "Medications" coded Resident # 8 as receiving an anticoagulant in the past seven days. The facility's "Nurse Practitioner's Note" for Resident # 8 dated 11/09/18 and signed by ASM (administrative staff member) # 7, nurse practitioner, at 12:45 p.m. documented in part, "HPI (History of Present Illness): ATSP (Asked To See Patient) for lab (laboratory) review. Male patient on Coumadin for DVT. INR: 3.5. Goal 2-3 (two to three). On 6 (six) mg daily. No s/sx of bleeding." Under "A/P (Assessment/Plan)" it documented, "Leg DVT - Stable. INR elevated. Hold Coumadin x1 (times one day) and recheck tomorrow." The Physician's telephone order documented, "Created Date: 11/9/18 at 17:14 (5:14 p.m.) Communication method: Phone." Documented "Order Summary: Coumadin Tablet 6 MG [milligram] (Warfarin Sodium) Give 6 MG by mouth in the evening for anticoagulant therapy Discontinue 11/9/18 17:14 (5:14 p.m.) Discontinue Date/Reason: on hold Confirmed By: name of (Licensed Practical Nurse)." A second physicians order date 11/9/2018 at 17:15 (5:15 p.m.) documented, "Order Summary: check pt/inr on sat [Saturday] 11/10/18 one time only for coumadin use 1 day."	F684		

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F684	Continued From page 207 The facility's "Anticoagulant Record" for Resident # 8 dated 11/09/18 documented, Current Anticoagulant Drug and Dose: "Coumadin 6 mg (milligrams)" "PT 3.5 INR: 41.6." Under "Action Taken by Physician" it documented, "Hold x 1 (times one day) re-check 11/10/18." Further review of the "Anticoagulant Record" failed to evidence results of a PT/INR for 11/10/18 as ordered by the physician. The facility's "Nurse's Note" for Resident # 8 dated 11/09/18 at 7:25 p.m. documented, "Hold Coumadin 6MG (milligrams) today 11/09/18 recheck PT/INR on SAT (Saturday) 11/10/18 will cont (continue) to monitor guest." Further review failed to evidence nurses notes documenting why the PT INR was not obtained on 11/10/18 as ordered by the physician and no documentation evidencing the physician was notified the laboratory testing was not obtained. LPN # 3 was asked what it meant if the laboratory [lab] results weren't written on the log. LPN # 3 stated, "It means that the lab wasn't drawn." An interview was conducted with RN (registered nurse) #8, the assistant director of nursing, on 8/6/19 at 3:12 p.m. The "Anticoagulant Record" for Resident #189 was reviewed with RN #8. When asked about the PT/INRs that were not completed, RN #8 stated, they should be done as ordered and if not done the physician should be notified and then we follow any order that they may give. On 08/05/19 at 5:10 p.m., ASM (administrative staff member) #1, administrator, ASM # 2, regional clinical coordinator and ASM #3 (director of nursing) were made aware of the	F684		

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F684	Continued From page 208 above concern. No further information was presented prior to exit. References: (1) A blood test that measures the time it takes for the liquid portion (plasma) of your blood to clot. This information was obtained from the website: https://medlineplus.gov/ency/article/003652.htm. (2) International normalized ratio (INR) is the preferred test of choice for patients taking vitamin K antagonists (VKA). It can also be used to assess the risk of bleeding or the coagulation status of the patients. Patients taking oral anticoagulants are required to monitor INR to adjust the VKA doses because these vary between patients. The INR is derived from prothrombin time (PT) which is calculated as a ratio of the patient's PT to a control PT standardized for the potency of the thromboplastin reagent developed by the World Health Organization (WHO) using the following formula: This information was obtained from the website: https://www.ncbi.nlm.nih.gov/books/NBK507707/ . (3) A condition that occurs when a blood clot forms in a vein deep inside a part of the body. It mainly affects the large veins in the lower leg and thigh, but can occur in other deep veins such as in the arms and pelvis. This information was obtained from the website: https://medlineplus.gov/ency/article/000156.htm. 3. The facility staff failed to obtain Resident #189's physician ordered PT (prothrombin)/	F684		

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F684	Continued From page 209 on 4/12/19, 6/27/19 and 7/26/19 as ordered by the physician to monitor and ensure the safe administration of the anticoagulant medication Coumadin. Resident #189 was admitted to the facility on 9/16/17, and was most recently readmitted on 7/16/19, with diagnoses that included but were not limited to: mechanical heart valve, stroke, high blood pressure and atrial fibrillation. (Atrial fibrillation is a condition characterized by rapid and random contraction of the atria of the heart causing irregular beats of the ventricles and resulting in decreased heart output and frequently clot formation in the atria). (1) The most recent MDS (minimum data set) assessment, a Medicare five day admission, with an assessment reference date of 7/23/19, coded the resident as scoring a "11" on the BIMS (brief interview for mental status score) indicating the resident was moderately impaired to make daily decisions. In Section N - Medications, the resident was coded as receiving an anticoagulant for the seven days of the look back period. *Coumadin is an anticoagulant/blood thinner that keeps your body from forming blood clots. (2) The comprehensive care plan dated, 12/19/18 and revised on 3/7/19, documented in part, "Focus: (Resident #189) is at risk for abnormal bleeding/bruising R/T (related to) medication use, anticoagulant diagnosis of A-Fib (atrial fibrillation), stroke." The "Interventions" documented in part, "Administer medications as ordered. Observe for ineffectiveness and side effects, report abnormal findings to the physician. Obtain labs (laboratory) and diagnostics as ordered and report abnormal	F684		

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F684	Continued From page 210 findings to the physician. ..." The nurse practitioner note dated, 8/10/18, documented, "INR goal 2.5 - 3.5." "Prothrombin time (PT) is a blood test that measures the time it takes for the liquid portion (plasma) of your blood to clot." "PT is measured in seconds. Most of the time, results are given as what is called INR (international normalized ratio)." "The most common reason to perform this test is to monitor your levels when you are taking a blood-thinning medicine called warfarin. You are likely taking this medicine to prevent blood clots. Normal Results: PT is measured in seconds. Most of the time, results are given as what is called INR (international normalized ratio). If you are taking warfarin to prevent blood clots, your provider will most likely, choose to keep your INR between 2.0 and 3.0." (4) Review of Resident #189's "Anticoaugulant Record" which was maintained separately by the facility revealed: The "Anticoagulant Record" dated, 4/11/19, documented the current Coumadin dose as 2.5 mg, INR 2.3, [below therapeutic goal placing the resident at risk for blood clots for a level too low and bleeding for a level to high]. A physician order dated, 4/11/18 in the EMR documented, "Recheck PT/INR level on 4/12/19 On 4/12/19, the "Anticoagulant Record" failed to evidence the PT/INR test was performed on 4/12/19. The form was dated 4/12/19 with the current Coumadin dose documented as 2.5 mg but the rest of the line was empty. Review of the nurse's note failed to evidence a nurse's note for 4/12/19. The test was not completed per the	F684		

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F684	Continued From page 211 physician order. On 6/26/19, the "Anticoagulant Record" documented the current Coumadin dose as 5.5 mg. The INR was documented as 4.3 [higher than the identified goal]. The physician directive documented, "Hold x1, recheck 6/27/19." The nurse practitioner note dated, 6/26/19, documented in part, "INR today 4.6. On Coumadin 5.5.mg (milligram) qd. (every day), goal 2.5 - 3.5, hold x 1 and recheck 6/27/19." The EMR documented physician orders dated 6/27/19 to hold the Coumadin and recheck on 6/27/19. The "Anticoagulant Record" failed to evidence documentation that Resident #189's INR was obtained on 6/27/19, as ordered by the physician. A physician order in the EMR dated, 7/25/19, documented, "PT/INR on 7/26/19, notify MD of results." On 7/26/19, the "Anticoagulant Record" documented the current Coumadin dose of 5 mg. The rest of the line was blank and there was no PT/INR documented. The PT/INR for Resident #189 was not obtained as ordered by the physician. There were no nurse's notes for 7/26/19. On 7/31/19 at 2:36 p.m., an interview was conducted with ASM (administrative staff member) #5 (Resident #189's physician at the facility). ASM #5 was asked why Coumadin must be monitored. ASM #5 stated Coumadin (levels) could quickly become out of control because the medication can variably react with food and other medications. ASM #5 stated this	F684		

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F684	Continued From page 212 is why the medication has to be monitored. An interview was conducted with RN (registered nurse) #8, the assistant director of nursing, on 8/6/19 at 3:12 p.m. The "Anticoagulant Record" for Resident #189 was reviewed with RN #8. When asked about the PT/INRs that were not completed, RN #8 stated, they should be done as ordered and if not done the physician should be notified and then we follow any order that they may give. When asked if the nurses should follow the documented physician directive or a physician order, RN #8 stated, "Yes, we should always follow the physician order." ASM #1, the administrator, ASM #2, the regional clinical coordinator, and ASM #3, the director of nursing were made aware of all of the above concerns on 8/6/19 at 5:19 p.m. No further information was provided prior to exit. (1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 55. (2) This information was obtained from the following website: https://vsearch.nlm.nih.gov/vivisimo/cgi-bin/query-meta?v%3Aproject=medlineplus&v%3Asources=medlineplus-bundle&query=coumadin. (3) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 450. (4) This information was obtained from the website: https://vsearch.nlm.nih.gov/vivisimo/cgi-bin/query-meta?v%3aproject=medlineplus&v%3asources=medlineplus-bundle&query=laboratory%20tests%20for%20PT%20calculation%20of%20INR&2.No further	F684		

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F684	Continued From page 213	F684		
F686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) 483.25(b) Skin Integrity 483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, it was determined that the facility staff failed to provide care and treatment for pressure injuries for one of 72 residents in the survey sample, Resident #62. The facility staff failed to implement pressure injury treatment for Resident #62 from 7/24/19 through 7/30/19. The findings include: Resident #62 was admitted to the facility on 2/17/17. Resident #62's diagnoses included but were not limited to difficulty swallowing, fractured left arm and repeated falls. Resident #62's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 6/6/19, coded the resident's	F686	Ftag 686 Resident #62: Treatment is being administered as ordered. The area continues to heal. No harm occurred as a result of this practice. Residents with pressure ulcers have the potential to be affected. DON or designee will educate licensed nursing staff on pressure ulcer identification and interventions. Education will include obtaining treatment orders for pressure ulcers. DON or designee conducted a skin sweep of current residents and reviewed orders for residents with pressure ulcers. Updates made as appropriate. Skin assessments will be reviewed in the clinical operations meeting. DON or designee will monitor skin assessments and new admissions 5 days a week for 4 weeks for any new pressure ulcers and corresponding treatment orders. Random treatment observations will be conducted on residents with pressure ulcers 2 times a week for 4 weeks. Any variances will be corrected and additional education or counseling will be provided as needed. Any concerns will be reported to the quality assurance committee monthly	9/20/19

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F686	Continued From page 214 cognition as severely impaired. Section M coded Resident #62 as not having any pressure injuries. Resident #62 discharged to the hospital on 7/19/19, and re-admitted to the facility on 7/23/19. Wound/Skin healing records dated 7/23/19 revealed the resident presented with the following skin areas: -a stage I pressure injury (1) to the left outer ankle measuring 0.5 cm (centimeters) in length by 0.5 cm in width -a stage II pressure injury (1) to the sacrum measuring 2 cm in length by 0.4 cm in width by 0.2 cm in depth - right buttock excoriation with no measurement -left buttock excoriation with no measurement Further review of Resident #62's clinical record failed to reveal any physician's order for the above pressure injuries/excoriation until 7/31/19. -A physician's order with a start date of 7/31/19 documented, "CLARIFICATION EFFECTIVE 7/23/19- APPLY SKIN PREP (2) TO LEFT OUTER ANKLE AND COVER WITH OPTIFOAM (3) DRSG (dressing) Q (every) HS (hour of sleep) DX (diagnosis): PREVENTATIVE MEASURES." The order was scheduled to be completed on the evening shift. - A physician's order with a start date of 7/31/19 documented, "CLARIFICATION EFFECTIVE 7/23/19- CLEANSE SACRUM WITH DERMAL WOUND CLEANSER- APPLY TRIAD (4) - COVER WITH OPTIFOAM DRSG. CHANGE Q HS DX: WOUND." The order was scheduled to be completed on the evening shift. -A physician's order with a start date of 7/31/19 documented, "CLARIFICATION EFFECTIVE 7/23/19- APPLY TRIAD TO LEFT AND RIGHT BUTTOCKS Q SHIFT AND PRN (as needed) DX: EXCORIATION."	F686	until resolved. Continued compliance will be monitored through the facility's quality assurance program. Additional education and monitoring will be initiated for any identified concerns. Completion Date: September 20, 2019	

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F686	Continued From page 215 Review of Resident #62's July 2019 MAR (medication administration record) failed to reveal evidence of treatment for the above pressure injuries/excoriation. Review of Resident #62's July 2019 TARs (treatment administration records) failed to reveal any evidence that treatment was provided for the above wounds from 7/23/19 through 7/30/19 (as evidenced by a check mark and nurses' initials indicating the treatments were done on 7/31/19 but only a "X" on all other dates). Review of nurses' notes and wound/skin healing notes from 7/23/19 through 7/30/19 failed to reveal documentation regarding the wounds and treatment for the wounds except for 7/23/19. Resident #62's baseline care plan dated 7/23/19 documented, "Pressure Sores (injuries)/Skin Care: Follow facility skin care protocol. Treatment as ordered..." On 7/31/19 at 3:21 p.m., an interview was conducted with LPN (licensed practical nurse) #2 (the nurse who cared for Resident #62 during the 3:00 p.m. to 11:00 p.m. [evening] shift on 7/28/19). LPN #2 was asked if Resident #62 had any wounds. LPN #2 stated the resident bit his finger and had a wound on the nail bed. LPN #2 was asked if Resident #62 had any other wounds. LPN #2 stated she believed the resident had excoriation on his bottom. LPN #2 was asked to describe any wound care she provided for Resident #62 on 7/28/19. LPN #2 stated she completed a dressing change on the resident's finger and applied cream to his bottom. When asked if she provided any other wound care, LPN #2 stated, "I can't remember	F686		

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F686	Continued From page 216 off the top of my head. No." When LPN #2 was asked how nurses evidence the treatments they provide, LPN #2 stated the nurses sign the treatments off on the TARs. LPN #2 was asked how nurses would know if there was a treatment, they were supposed to complete. LPN #2 stated the treatment would be on the MAR if not on the TAR. LPN #2 was shown Resident #62's July 2019 TAR with the above wound care orders dated 7/31/19 and asked if a treatment scheduled on the evening shift should be done on the 3:00 p.m. to 11:00 p.m. shift. LPN #2 stated it should. On 7/31/19 at 4:33 p.m., an interview was conducted with LPN #13 (the nurse who cared for Resident #62 during the 3:00 p.m. to 11:00 p.m. [evening] shift on 7/24/19). LPN #13 was asked how nurses would know if there was a treatment, they were supposed to complete. LPN #13 stated, "If not on the TAR then there is no way I would know. Especially because I'm a floater (meaning he works on different units)." LPN #13 was asked if Resident #62 had any wounds. LPN #13 stated the resident had a wound on his finger and that was the only wound he was aware of. LPN #13 was asked if he had provided any wound care other than finger wound care for Resident #62 since the resident was re-admitted from the hospital on 7/23/19. LPN #13 stated, "No. That's the only one." On 7/31/19 at 5:00 p.m., an interview was conducted with RN (registered nurse) #8, the assistant director of nursing. RN #8 was shown the wound care orders dated 7/31/19 (to be effective since 7/23/19) and was asked to explain the orders. RN #8 stated she was completing Resident #62's skin assessment and treatments on this date (7/31/19) and during her	F686		

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F686	Continued From page 217 review of the physician's orders, she saw that the resident did not have treatment orders for his pressure injuries/excoriation. RN #8 stated she completed treatments for Resident #62's pressure injuries/excoriation either on the day of re-admission or the day after, and on this date (7/31/19). RN #8 stated she thought the evening nurses were completing treatments for the pressure injuries/excoriation on all the other days. When asked how she knew what treatments to complete, RN #8 stated she used the physician approved facility skin protocol. RN #8 was asked why she wrote the clarification orders on 7/31/19 and dated them to be effective since 7/23/19. RN #8 stated she knew she did wound care on some days and she knew the nurses applied triad cream to the excoriation. RN #8 was made aware the clarification orders included dressings and per interviews with two nurses who cared for Resident #62 during the evening shifts, they did not apply dressings. RN #8 stated she assumed the nurses were applying triad cream. When asked about her knowledge of the other nurses were applying dressings, RN #8 stated she could not account for that. On 8/1/19 at 10:42 a.m., Resident #62's pressure injuries were observed with and measured by ASM (administrative staff member) #7 (the nurse practitioner). The pressure injury on the left outer ankle was healed. The pressure injury on the sacrum was verbalized as stage II by ASM #7 and measured 0.5 cm (length) by 0.5 cm (width) (with no depth). On 8/6/19 at 11:25 a.m., ASM (administrative staff member) #1 (the administrator), ASM #2 (the regional clinical coordinator) and ASM #3 (the director of nursing) were made aware of the above concern.	F686		

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F686	Continued From page 218 The facility document titled, "PRESSURE ULCER (injury) IDENTIFICATION AND TREATMENT PROTOCOLS" documented the definition of the stages of pressure injuries, multiple interventions (including turning/repositioning, dietary consultations and the monitoring of labs) that can be implemented and various treatment options for all stages of pressure injuries. No further information was presented prior to exit. (1) "A pressure injury is localized damage to the skin and underlying soft tissue usually over a bony prominence or related to a medical or other device. The injury can present as intact skin or an open ulcer and may be painful. The injury occurs as a result of intense and/or prolonged pressure or pressure in combination with shear. The tolerance of soft tissue for pressure and shear may also be affected by microclimate, nutrition, perfusion, co-morbidities and condition of the soft tissue. Stage 1 Pressure Injury: Non-blanchable erythema of intact skin. Intact skin with a localized area of non-blanchable erythema, which may appear differently in darkly pigmented skin. Presence of blanchable erythema or changes in sensation, temperature, or firmness may precede visual changes. Color changes do not include purple or maroon discoloration; these may indicate deep tissue pressure injury. Stage 2 Pressure Injury: Partial-thickness skin loss with exposed dermis Partial-thickness loss of skin with exposed dermis. The wound bed is viable, pink or red, moist, and may also present as an intact or ruptured serum-filled blister. Adipose (fat) is not	F686		

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F686	Continued From page 219 visible and deeper tissues are not visible. Granulation tissue, slough and eschar are not present. These injuries commonly result from adverse microclimate and shear in the skin over the pelvis and shear in the heel. This stage should not be used to describe moisture associated skin damage (MASD) including incontinence associated dermatitis (IAD), intertriginous dermatitis (ITD), medical adhesive related skin injury (MARSI), or traumatic wounds (skin tears, burns, abrasions)." This information was obtained from the website: https://cdn.ymaws.com/npuap.site-ym.com/resource/resmgr/npuap_pressure_injury_stages.pdf (2) "SKIN-PREP is a liquid film-forming dressing that, upon application to intact skin, forms a protective film to help reduce friction during removal of tapes and films." This information was obtained from the website: http://www.smith-nephew.com/professional/products/advanced-wound-management/skin-prep/# (3) An Optifoam dressing is used to treat wounds. This information was obtained from the website:https://www.medline.com/product/Optifoam-Adhesive-Foam-Wound-Dressings/Foam-Dressings/Z05-PF00157 (4) Triad paste is used to treat wounds. This information was obtained from the website: https://www.medline.com/product/Triad-Hydrophilic-Paste-Wound-Dressing-by-Coloplast/Lotions-Creams-Ointments/Z05-PF165631?question=triad&index=P1&indexCount=1	F686		

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F687 F687 SS=D	Continued From page 220 Foot Care CFR(s): 483.25(b)(2)(i)(ii) 483.25(b)(2) Foot care. To ensure that residents receive proper treatment and care to maintain mobility and good foot health, the facility must: (i) Provide foot care and treatment, in accordance with professional standards of practice, including to prevent complications from the resident's medical condition(s) and (ii) If necessary, assist the resident in making appointments with a qualified person, and arranging for transportation to and from such appointments. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review and clinical record review, it was determined the facility staff failed to ensure foot care was provided for one of 72 sampled residents, (Resident #76). Resident #76, a diabetic was observed with the toenails on both feet extending over the edge of his toes. The residents nails had not been trimmed by a licensed nurse and he had not been seen by the podiatrist. The findings include: Resident #76 was admitted to the facility on 6/28/17 with diagnoses that included but were not limited to: stroke, dementia, diabetes and high blood pressure. The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 6/919, coded the resident as scoring a "10" on the BIMS (brief interview for mental status)	F687 F687	Ftag 687 Resident #76: Nails were trimmed. No negative outcome as occurred from this practice. All residents have the potential to be affected. DON or designee will educate CNAs and licensed nursing staff on nail care and when to refer to podiatry services. DON or designee conducted an assessment of toenails for residents currently in the facility. Nail care will be provided as needed, and podiatry services will be coordinated as needed. Nail care has been provided. DON or designee will monitor toenails at random 5 days a week for 1 week, 3 days a week for 2 weeks, weekly for 4 weeks, and monthly for 3 months. Any variances will be corrected and additional education or counseling will be provided as needed Any concerns will be reported to the quality assurance committee monthly until resolved. Continued compliance will be monitored through the facility quality assurance program. Additional education and monitoring will be initiated for any identified concerns.	9/20/19

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F687	Continued From page 221 score, indicating he was moderately impaired to make daily cognitive decisions. The resident was coded as requiring extensive assistance of one staff member for most of his activities of daily living. Observation was made of Resident #76's toes on 8/2/19 at 2:45 p.m. His feet were uncovered and visible. His toenails on both feet were extending over the edge of his toes. The third toe on each foot was approximately one quarter of an inch over the edge of the toe with a pointed sharp corner that was resting on the first toe. The first toes were observed and there were no reddened areas. The big toe on the left foot was deformed and not long. The big toe on the right foot was long and extending over the edge of the toe. The comprehensive care plan dated, 1/10/19, documented in part, "Focus:(Resident #76) is at risk for fluctuation in blood sugar levels R/T (related to) dx (diagnosis) of DM (diabetes mellitus)." The "Interventions" documented in part, "Check body for breaks in skin during care/showers and treat promptly as ordered by physician. Inspect feet during care/showers for open areas, sores, pressure areas, blisters, edema or redness." An interview was conducted with CNA (certified nursing assistant) #3 on 8/2/19 at 22:40 a.m. When asked how do resident's toe nails get cut, CNA #3 stated, "We try to trim them when they need it during ADL (activity of daily living) care an showers." When asked if a resident is a diabetic, who cuts the nails, CNA #3 stated, "The nurses cut the residents who have diabetes." An interview was conducted with RN (registered	F687	Completion Date: September 20, 2019	

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F687	Continued From page 222 nurse) #5, unit manager, on 8/2/19 at 11:43 a.m. When asked who cuts resident's toenails, RN #5 stated, "If they are not a diabetic, the nurses and CNAs can cut them." When asked if the residents get referred to a podiatrist if the staff cannot cut the nails, RN #5 stated, "The social worker handles the list that she gets from the nurses." RN #5 was asked to observe Resident #76's toenails. When asked if the resident's toenails were in need of cutting, RN #5 stated, "Yes." The podiatry list for the past several weeks was requested. On 8/2/19 at 12:00 p.m., other staff member (OSM) #11, the social worker, presented the podiatry lists dated 6/20/19, 7/11/19, 7/26/19 and 8/2/19. Resident #76 did not appear on the first three lists but OSM #11 stated she had put Resident #76 on the list today. The facility policy, "Nail Care - Fingers, Toes & Diabetic," documented in part, "Policy: Nail and foot care for diabetic guests will be provided by the licensed nurse as directed by the physician's order. The nails of diabetic guest will not be trimmed by nursing assistants...Diabetic Care: The licensed nurse should give nail and/or foot care to the diabetic guest unless otherwise directed by the physician...Before completing nail and/or foot care, the licensed nurse should consult the physician for guest with Peripheral Vascular Disease (PVD), localized conditions (e.g. fungal infections, bleeding cuticles, etc.) thick mycotic nails, or ingrown toenails. Make referral to the podiatrist at the director of a physician's order." Administrative staff member (ASM) #1, the administrator, ASM #2, the regional clinical consultant and ASM #3, the director of nursing were made aware of the above findings on	F687		

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F687	Continued From page 223 8/2/19 at 2:00 p.m. No further information was provided prior to exit.	F687		
F695 SS=E	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, facility document review, clinical record review, it was determined that the facility staff failed to provide respiratory care and services consistent with professional standards of practice, the comprehensive person-centered care plan for five of 72 residents in the survey sample; (Resident #526, # 91, # 96, #59, and #1). The facility Staff failed to administer oxygen per physician orders for Residents #526, #91, and #1, failed to obtain orders for Resident #96's use of BiPAP (Bi-level Positive Airway Pressure), failed to administer a nebulizer treatment per orders and professional standards to Resident #91 and failed to store respiratory equipment in a sanitary manner for Resident # 91, 96, 59. The findings include.	F695	F695 Resident #526: No longer resides in the facility Resident #91: No longer resides in the facility Resident #96: Bipap orders were obtained and the mask is being stored properly. No negative outcome occurred as a result of this practice. Resident #59: The incentive spirometer was stored properly. No negative outcome occurred as a result of this practice. Resident #1: Oxygen has been placed on the correct settings. No negative outcome has occurred as a result of this practice. Residents receiving oxygen, nebulizer, incentive spirometer or BiPAP treatments have the potential to be affected. DON or designee will educate licensed nursing staff on obtaining and following physician orders for oxygen and BiPAP, and the proper storage of respiratory equipment. DON or designee will audit residents with BiPAP, oxygen, nebulizers, and incentive	9/20/19

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F695	Continued From page 224 1. The facility staff failed to administer Resident #526's oxygen according to the physician's orders. Resident #526 was admitted to the facility on 7/26/19, with diagnoses including but are not limited to, left hip fracture, lung cancer, high blood pressure and pacemaker. Due to the recent admission, the MDS (Minimum Data Set) had not yet, been completed. According the "Nursing Admission" note dated 7/26/19, Resident #526 was alert and oriented to time, place, and person; requires extensive assistance for toileting; total care for transfers and bed mobility; and continent of bladder and bowel. On 7/30/19 at 12:08 PM, 7/31/19 at 9:29 AM, and 5:28 PM, an observation of Resident #526's oxygen, concentrator's flow rate was made. Resident #526's oxygen concentrator flowrate was observed at 2 1/2 L/min (Liters per minute) during each observation. A review of the clinical record revealed a physician's order dated 7/26/19, documented in part the following, "Oxygen 3L/min via nasal cannula SOB (shortness of breath), every shift for SOB/Wheezing." A review of the clinical record revealed a TAR (Treatment Administration Record) for July 2019, documented in part the following with a start date of 7/26/19, "Oxygen 3L/min via nasal cannula SOB, every shift for SOB/Wheezing." A review of the clinical record failed to reveal a care plan for oxygen administration. On 7/31/19 at 2:28 PM, an interview was conducted with LPN (Licensed Practical Nurse)	F695	spirometers to ensure physicians orders are being followed and respiratory equipment is being stored properly. DON or designee will monitor residents on oxygen for correct settings, nebulizers, BiPAP, and incentive spirometers for proper storage 5 times a week for 1 week, 3 times a week for 2 weeks, weekly for 4 weeks, and monthly for 3 months. Any variances will be corrected and additional education or counseling will be provided as needed Any concerns will be reported to the quality assurance committee monthly until resolved. Continued compliance will be monitored through the facility□quality assurance program. Additional education and monitoring will be initiated for any identified concerns. Completion Date: September 20, 2019	

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F695	Continued From page 225 #3. When LPN #3 was asked the process to ensure the oxygen flow meter is set at the physician's ordered rate, LPN #3 stated, "You check the orders, then you check the concentrator to make sure it is at the right rate by the line number on the flow meter and the ball. The ball would be at the center of the line." When LPN #3 was asked about residents' oxygen not being set at the physician ordered rate right rate, LPN #3 stated, "Respiratory failure, shortness of breath, tachypnea (rapid breathing), and low oxygen saturation." When LPN #3 was asked to demonstrate how to set the oxygen concentrator's flow meter, LPN #3 stated, "You have to get at eye level and look at the lines." LPN #3 then pointed to each line and stated, "1, 2, 3, 4, and there is 5." LPN #3 then stated, "The ball would move as you turn the knob and you put the ball to the center of the line that is ordered." On 7/31/19 at 3:34 PM, an interview with LPN #5 was conducted. When LPN #5 was asked what the process to make sure the oxygen concentrator flow meter is at, the right rate is, LPN #5 stated, "You look at the dial and set it to the physician's orders." When asked what the rate should be for Resident #526, LPN #5 stated, "Three." When LPN #5 was asked to demonstrate how to read the oxygen concentrator's flow meter, LPN #5 demonstrated getting down to eye level with the flow meter. When LPN #5 was asked where the flow meter ball was set at, LPN #5 stated, "2 1/2" and pointed to the 2 1/2 line. LPN #5 then touched the knob and moved the flow meter ball. A review of the facility's operator's manual for "(Name of) Oxygen Concentrators" documented in part, "...DO NOT change the L/min setting on the flowmeter unless a change has been	F695		

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F695	Continued From page 226 prescribed by your physician or therapist...Flowrate: 1. Turn the flowrate knob to the setting prescribed by your physician or therapist. Note: To properly read the flowmeter, locate the prescribed flowrate line on the flowmeter. Next, turn the flow knob until the ball rises to the line. Now, center the ball on the L/min. line prescribed...." According to Fundamentals of Nursing, 6th edition, Potter and Perry, 2005, page 1122, "Oxygen should be treated as a drug. It has dangerous side effects, such as atelectasis or oxygen toxicity (Thomson, 2002). As with any drug, the dosage or concentration of oxygen should be continuously monitored. The nurse should routinely check the physician's orders to verify that the client is receiving the prescribed oxygen concentration. The six rights of medication administration also pertain to oxygen administration." On 8/2/19 at 1:48 PM, ASM (Administrative Staff Member) #1, the Administrator, ASM #3, the Director of Nursing, and ASM #2, the Regional Clinical Coordinator, were made aware of the findings. No further information was provided by the end of the survey. 2. a. The facility staff failed to administer oxygen per the physician order for Resident #91. Resident #91 was admitted to the facility on 6/20/19 with diagnoses that included but were not limited to: cancer and COPD (chronic obstructive pulmonary disease - a general term for chronic, nonreversible lung disease that is	F695		

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F695	Continued From page 227 usually a combination of emphysema and chronic bronchitis) (1). The most recent MDS (minimum data set) assessment, an admission assessment, with an assessment reference date of 6/27/19, coded the resident as scoring a "14" on the BIMS (brief interview for mental status) score, indicating he was cognitively intact to make daily decisions. In Section O - Special Treatments, Procedures and Programs, the resident was coded as using oxygen while a resident in the facility. Observation was made on 7/30/19 at 12:26 p.m. of Resident #91 in his bed, asleep with his oxygen on via a nasal cannula (a two-pronged tubing that inserts into the nose) connected to an oxygen concentrator. The oxygen concentrator, flow rate was set at 3 LPM (liters per minute). A second observation was made of Resident #91 on 7/30/19 at 4:15 p.m. The oxygen was in use by the resident and the oxygen concentrator, flow rate was set at 3 LPM. Observation was made on 7/31/19 at 8:38 a.m. and 1:25 p.m. of Resident #91 in his bed with his oxygen on via the nasal cannula. The oxygen concentrator, flow rate was set at 3 LPM. Another surveyor verified this. The physician order dated, 7/26/19, documented, "O2 (oxygen) 2L/min (liters per minute) via NC (nasal cannula) every shift for shortness of breath. The comprehensive care plan dated, 7/3/19, documented in part, "Focus: (Resident #91) has a potential for difficulty breathing and risk for respiratory complications R/T (related to) dx (diagnosis) of COPD, requires O2." The	F695		

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F695	Continued From page 228 "Interventions" documented in part, "Administer mediations & treatments per physician orders. Monitor for ineffectiveness, side effects and adverse reactions, report abnormal findings to the physician." On 7/31/19 at 1:29 p.m., an interview and observation of Resident #91's flow rate was conducted with RN (registered nurse) #5, the unit manager. RN #5 was asked to view Resident #91's oxygen concentrator and state the flow rate of oxygen the resident was currently receiving. RN #5 observed the oxygen flow rate and stated, "It's [oxygen flow rate] set at 3 LPM [liters per minute]. I checked it this morning." RN #5 was asked to verify the physician order for Resident #91's oxygen. RN #5 reviewed the Resident #91's physician orders for oxygen and stated, "He should be on 2 LPM." Administrative staff member (ASM) #1, the administrator, ASM #2, the regional clinical coordinator and ASM #3, the director of nursing, were made aware of the above concern on 8/2/19 at 2:00 p.m. No further information was provided prior to exit. (1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 124. 2. b. The facility staff failed administer Resident # 91's prepared nebulizer treatment of Ipratropium-Albuterol Solution as ordered in accordance with professional standards. Staff left the prepared treatment in the room when the resident requested to eat lunch and documented on the MAR (medication administration record), that the treatment had been administered.	F695		

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F695	Continued From page 229 Observation was made of Resident #91's room on 7/31/19 at 1:25 p.m. The nebulizer mask was observed hanging off the nebulizer machine, not stored in a bag. Liquid was present in the nebulizer, medication storage container, going halfway up the container. The physician order dated, 6/20/19, documented, "Ipratroplum-Albuterol solution, 0.5 - 2.5 MG (milligrams)/3 ML (milliliters) 3 ML inhale orally every 6 hours for COPD give via jet (nebulizer)." Ipratropium-Albuterol Solution is used to prevent wheezing, difficulty breathing, chest tightness, and coughing in people with chronic obstructive pulmonary disease COPD. (2) The July 2019 Medication Administration Record (MAR) documented the above physician order. On 7/31/19 at 12:00 p.m., the medication was signed off as administered. The comprehensive care plan dated, 7/3/19, documented in part, "Focus: (Resident #91) has a potential for difficulty breathing and risk for respiratory complications R/T (related to) dx (diagnosis) of COPD, requires O2." The "Interventions" documented in part, "Administer mediations & treatments per physician orders. Monitor for ineffectiveness, side effects and adverse reactions, report abnormal findings to the physician." An interview was conducted with RN (registered nurse) #5 on 7/31/19 at 1:29 p.m. RN #5 was asked to view Resident #91's nebulizer mask and medication storage container. When asked if there was medication in the container, RN #5 stated, "Yes, that looks like a dose of the medication in there." When asked if the solution	F695		

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F695	Continued From page 230 should be there, RN #5 stated, "No, it should not be there. The resident should be observed starting the treatment." An interview was conducted with LPN (licensed practical nurse) #2, on 7/31/19 at 2:03 p.m. When asked if she gave Resident #91 his nebulizer treatment today, LPN stated, "I put it in there right before 12:00 p.m. He requested to eat his lunch." LPN #2 stated, "He was initially going to do it but then realized it was close to lunch." LPN #2 stated, "I should have removed the medication from the nebulizer and taken it back after lunch." The "Medication Administration" policy documented in part, "9. Administer the medication. (Note: Remain with the guest while administering oral medications to verify their consumption). 10. Initial the guest's Medication Administration Record (MAR) immediately following administration. 11. Record any medication omissions including date, time, and reason on the back of the Medication Administration Record (MAR)." The "Aerosolized Medication Administration" policy documented in part, "6. Assemble the nebulizer kit. 7. Add prescribed medication and diluent to nebulizer chamber. 8. Attach tubing to nebulizer compressor. 9. Place aerosol mask over mouth or trach or insert mouthpiece into guest's mouth. 10. Turn on nebulizer compressor. 11. Instruct guest to take slow deep breaths with a slight pause at the end of the inhalation. Guest should breathe at normal respiratory rate. 12. Administer therapy until medication is depleted, treatments usually last 10 -15 minutes." Administrative staff member (ASM) #1, the	F695		

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F695	Continued From page 231 administrator, ASM #2, the regional clinical coordinator and ASM #3, the director of nursing, were made aware of the above concern on 8/2/19 at 2:00 p.m. On 8/6/19 at 10:18 a.m., ASM #2 was asked which professional standards of practice the facility follows. ASM #2 stated, "We follow our policies and use Lippincott." No further information was provided prior to exit. (1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 124. (2) This information was obtained from the following website: https://medlineplus.gov/druginfo/meds/a601063.html 2. c. The facility staff failed to store Resident #91's nebulizer mask in a sanitary manner. During multiple observations Resident #91's nebulizer mask was observed hanging by the strap from the nebulizer machine and not stored in a bag. Observation was made on 7/30/19 at 4:15 p.m. A nebulizer mask was noted to be hanging by the strap on the nebulizer machine. A plastic bag was noted to be sitting on top of the nightstand next to the nebulizer machine. A second observation was made on 7/31/19 at 8:38 a.m. The nebulizer mask was again noted to be hanging by the strap on the nebulizer machine. A third observation was made on 7/31/19 at 1:25 p.m. The nebulizer mask was again noted to be hanging off the nebulizer machine.	F695		

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F695	Continued From page 232 An interview was conducted with RN (registered nurse) #5, the unit manager, on 7/31/19 at 1:29 p.m. When shown the nebulizer mask and the empty bag sitting on the nightstand in Resident #91's room, RN #5 stated, "It should be stored in a bag when not in use." The facility policy, "Aerosolized Medication Administration" documented in part, "15. Disassemble nebulizer set, rinse with water, and shake dry or place on paper towel to air dry. Once unit is dry, place in bag." Administrative staff member (ASM) #1, the administrator, ASM #2, the regional clinical consultant and ASM #3, the director of nursing were made aware of the above findings on 8/2/19 at 2:00 p.m. No further information was provided prior to exit. 3. The facility staff failed to obtain a physician's order for Resident # 96's use of a BIPAP and failed to store the residents BiPAP mask in a sanitary manner. Resident # 96 was admitted to the facility on 07/04/2019 with diagnoses that included but were not limited to: respiratory failure (1), obstructive sleep apnea (2). Resident # 96's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 07/10/19, coded Resident # 96 as scoring a 14 on the brief interview for mental status (BIMS) of a score of 0 - 15, 15 - being cognitively intact for making daily decisions. Section O "Special Treatments, Procedures and Programs" failed to code	F695		

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F695	Continued From page 233 Resident # 96 for the use of oxygen. On 07/30/19 at 2:40 p.m., and on 07/31/19 at 10:20 a.m., observations of Resident #96 revealed she was lying in bed. Observations of Resident # 96's bedside table revealed a Bi-PAP (bi-level positive airway pressure) (3) mask sitting on top of the dresser uncovered. On 08/01/19 at 8:40 a.m., observation of Resident #96 revealed she was lying in bed. Observation of Resident # 96's bedside table revealed a Bi-PAP mask sitting on top of the dresser uncovered. When asked if she removes her Bi-PAP mask by herself, Resident # 96 stated, "Yes." When asked if she staff instructed to place the mask in a bag when it was not in use, Resident # 96 stated, "No, they told me it was their (the nurse's) job to do that." The POS (physician order sheet) dated July 2019 failed to evidence an order for the use of a BiPAP. The comprehensive care plan for Resident # 96 with a revision on 08/01/2019 documented, "Need. (Resident # 96) has potential for difficulty breathing and risk for respiratory complications R/T (related to): dx (diagnosis) of Obstructive Sleep Apnea. Requires Bi-PAP machine. Guest removes Bi-PAP mask at times. Revision on: 08/01/2019." On 08/01/19 at approximately 4:00 p.m. a request was made to ASM # 1 (administrative staff member) #1, the administrator, and ASM # 2, regional clinical coordinator for a copy of the physician's order for Resident # 96's use of a BiPAP. On 08/02/19 at approximately 8:00 a.m., ASM #	F695		

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F695	Continued From page 234 1 informed this surveyor that the facility did not have a physician's order for the Resident # 96's use of a BiPAP and that they were currently obtaining an order. At approximately 2:00 p.m., ASM # 1 provided this surveyor a copy of the physician's telephone order dated 08/02/2019. The order documented, "BIPAP ON QHS (every hours of sleep) - OFF IN THE AM (a.m.) - BIPAP 21/9 WITH 4 (four) LITERS OF OXYGEN DX (diagnosis): SLEEP APNEA every evening and night shift for SLEEP APNEA." On 08/05/19 at approximately 5:55 p.m., a request was made to ASM (administrative staff member) # 1 for a policy regarding the storage of BiPAP mask. On 8/6/19 at 10:18 a.m., administrative staff member (ASM) #2, the regional clinical coordinator, was asked what standard of practice the facility follows, ASM #2 stated, "We follow our policies and Lippincott." On 08/06/2019 at 4:45 p.m., an interview was conducted with RN (registered nurse) # 2, unit manager. When asked how a Bi-PAP mask be stored when not in use RN # 2 stated, "It should be in a plastic bag with the date and name of the resident on it." On 08/06/19 at approximately 5:00 p.m., ASM stated they didn't have a policy regarding the storage of BiPAP mask. The facility's policy "Medication Administration" documented in part, "Policy: All medications and treatments shall be initiated, administered, and/or discontinued in accordance with written physician orders (either written or per telephone order)."	F695		

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F695	Continued From page 235 On 08/051/19 at approximately 5:10 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, director of nursing, and ASM # 3, were made aware of the above findings. No further information was provided prior to exit. References: (1) When not enough oxygen passes from your lungs into your blood. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/respiratoryfailure.html. (2) Obstructive sleep apnea (OSA) is a problem in which your breathing pauses during sleep. This occurs because of narrowed or blocked airways. This information was obtained from the website: https://medlineplus.gov/ency/article/000811.htm. (3) Stands for Bi-level Positive Airway Pressure, and is very similar in function and design to a CPAP machine (continuous positive airway pressure). Similar to a CPAP machine, A BiPAP machine is a non-invasive form of therapy for patients suffering from sleep apnea. Both machine types deliver pressurized air through a mask to the patient's airways. The air pressure keeps the throat muscles from collapsing and reducing obstructions by acting as a splint. Both CPAP and BiPAP machines allow patients to breathe easily and regularly throughout the night. This information was obtained from the website: https://www.alaskasleep.com/blog/what-is-bipap-therapy-machine-bilevel-positive-airway-pressure. 4. The facility staff failed to store Resident #	F695		

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F695	Continued From page 236 Resident # 59 was admitted to the facility on 05/22/2015 with diagnoses that included but were not limited to: shortness of breath and atelectasis (1). Resident # 59's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 06/09/19, coded Resident # 59 as scoring a eight on the brief interview for mental status (BIMS) of a score of 0 - 15, eight - being moderately impaired of cognition for making daily decisions. On 07/30/19 at 5:05 p.m., 07/31/19 at 7:40 a.m. and on 07/31/19 at 8:55 a.m., observations of Resident # 59's room revealed an incentive spirometer (2) uncovered sitting the over-the-bed table next to the resident's bed. On 07/31/19 at 8:55 a.m., an interview was conducted with Resident # 59 regarding the use of the incentive spirometer. When asked if she uses the spirometer, Resident # 59 stated, "Sometimes." On 07/31/19 at 3:06 p.m., observation of Resident # 59's room revealed an incentive spirometer uncovered sitting the over-the-bed table next to the resident's bed. The POS (physician's order sheet) for Resident # 59 dated July 2019 documented, "Incentive spirometer 10xhr (ten times per hour) while awake every shift for atelectasis for 30 days. Order Date: 07/09/2019. End Date: 08/08/2019." On 07/31/19 at 3:08 p.m., an interview was conducted with RN # 2, unit manager. When asked if an incentive spirometer was a piece of respiratory equipment, RN # 2 stated, "Yes."	F695		

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F695	Continued From page 237 When how the incentive spirometer is stored when not in use, RN # 2 stated, "It is stored in a bag when not in use." On 07/031/19 at approximately 6:05 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, director of nursing, and ASM # 3, were made aware of the above findings. On 08/05/19 at approximately 5:55 p.m., a request was made to ASM (administrative staff member) # 1 for a policy regarding the storage of an incentive spirometer. On 8/6/19 at 10:18 a.m., administrative staff member (ASM) #2, the regional clinical coordinator, was asked what standard of practice the facility follows, ASM #2 stated, "We follow our policies and Lippincott." A review of the facility policy "Hyperinflation Therapy Incentive Spirometer" documented in part the following, " ...The incentive spirometer is for single guest use. It is to be stored in a plastic bag at the guest's bedside when not in use ..." No further information was provided prior to exit. References: (1) The collapse of part or, much less commonly, all of a lung. Atelectasis is caused by a blockage of the air passages (bronchus or bronchioles) or by pressure on the outside of the lung. This information was obtained from the website: https://medlineplus.gov/ency/article/000065.htm. (2) Incentive Spirometer: An incentive spirometer is a device used to help you keep your lungs healthy after surgery or when you	F695		

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F695	Continued From page 238 have a lung illness, such as pneumonia. Using the incentive spirometer teaches you how to take slow deep breaths. Deep breathing keeps your lungs well-inflated and healthy while you heal and helps prevent lung problems, like pneumonia. This information was obtained from the following website: https://medlineplus.gov/ency/patientinstructions/000451.htm 5. The facility staff failed to administer oxygen to Resident # 1 at the flow rate prescribed by the physician. Resident # 1 was admitted to the facility on 5/12/2011 with a readmission on 10/19/2017, with diagnoses that included but were not limited to heart failure (1), pneumonia (2), and acute respiratory failure (3). Resident # 1's most recent MDS (minimum data set), a significant change assessment with an ARD (assessment reference date) of 06/12/19, coded Resident # 1 as scoring a 13 on the staff assessment for mental status (BIMS) of a score of 0 - 15, 13- being cognitively intact for making daily decisions. Section O (Special treatments, procedures, and programs) on the MDS coded Resident # 1 as receiving oxygen therapy. An observation on 07/30/19 at 2:15 p.m. revealed Resident # 1 receiving oxygen via a nasal cannula connected to an oxygen concentrator. Resident #1's oxygen concentrator was running and was set on the line between 1 (one) and 2 (two) liters per minute. An additional observation on 07/30/19 at 4:06 p.m., 07/31/19 at 7:40 a.m. and 2:30 p.m. revealed the same findings as stated above.	F695		

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F695	Continued From page 239 The comprehensive care plan for Resident # 1, "[name of resident] is at risk for decreased cardiac output R/T (related to): CHF (congestive heart failure) w/ (with) oxygen use, HTN (high blood pressure), history of CVA (stroke) Date Initiated 01/29/2019 Revision on: 01/29/2019." Under "Interventions" it documented, "Provide O2 (oxygen) as ordered 2lpm (two liters per minute), obtain O2 sats (saturations) as ordered and notify physician of abnormal findings. Date Initiated: 01/29/2019." The POS (physicians order sheet) dated "07/31/2019" for Resident # 1 documented, "O2 2 (two) liters continuous per nasal cannula (oxygen delivery device) every shift for CHF call Dr (doctor) if pulse ox (oximetry) 89% or below. Order Date: 05/08/2018. Start Date: 05/08/2018." On 7/31/19 at 2:40 p.m., an interview was conducted with LPN (licensed practical nurse) # 16, regarding the administration of oxygen. LPN # 16 stated, "We make sure the O2 is set to the correct level that is ordered." When asked how staff set the flow rate of oxygen, LPN # 16 stated, "You set the ball on the line for the number that the O2 is ordered. You look directly at the ball at eye level." When asked what the lines on the flowmeter mean, LPN # 16 stated, "The lines on the gauge start at one, one and a half, two, two and a half, up and up." LPN # 16 stated that each line on the gauge was one-half. On 7/31/19 at 2:45 p.m. and observation was made with LPN # 16 of Resident #1's oxygen concentrator. LPN # 16 examine the oxygen concentrator and stated, "Oh, it is on 1 [0ne half] (liters per minute), sometimes it vibrates down, sometimes that happens." LPN # 16 adjusted the flow meter on the concentrator to	F695		

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F695	Continued From page 240 2LPM (liters per minute) at eye level. When asked if Resident #1's oxygen was administered as ordered to Resident #1, LPN # 16 stated that the oxygen was not being administered as ordered by the physician. On 8/6/19 at 10:18 a.m. administrative staff member (ASM) #2, the regional clinical coordinator, was asked what standard of practice the facility follows. ASM #2 stated, "We follow our policies and Lippincott." The manufacturer's instruction manual for the oxygen concentrator located in Resident # 1's room documents "Section 6.3.3 Flowrate 1. Turn the flowrate knob to the setting prescribed by your physician or therapist. To properly read the flowmeter, locate the prescribed flowrate line on the flowmeter. Next, turn the flow knob until the ball rises to the line. Now, center the ball on the L/min (liters per minute) line prescribed." According to Lippincott, page 242, read in part: "Nursing Assessment and Interventions: 3. Administer oxygen in the appropriate concentration." On 07/31/19 at approximately 6:00 p.m., ASM (administrative staff member) # 1, the administrator, ASM # 2, regional clinical coordinator and ASM # 3, director of nursing were made aware of the findings. No further information was provided prior to exit. Reference: 1. Heart failure A condition in which the heart is no longer able to pump oxygen-rich blood to the rest of the body efficiently. This causes symptoms to occur	F695		

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F695	Continued From page 241 throughout the body. This information was obtained from the website: https://medlineplus.gov/ency/article/000158.htm. 2. Pneumonia An infection in one or both of the lungs. Many germs, such as bacteria, viruses, and fungi, can cause pneumonia. You can also get pneumonia by inhaling a liquid or chemical. This information was obtained from the website: https://medlineplus.gov/pneumonia.html. 3. Respiratory failure Respiratory failure is a condition in which your blood doesn't have enough oxygen or has too much carbon dioxide. Sometimes you can have both problems. When you breathe, your lungs take in oxygen. The oxygen passes into your blood, which carries it to your organs. Your organs, such as your heart and brain, need this oxygen-rich blood to work well. Another part of breathing is removing the carbon dioxide from the blood and breathing it out. Having too much carbon dioxide in your blood can harm your organs. This information was obtained from the website: https://medlineplus.gov/respiratoryfailure.html	F695		
F698 SS=D	Dialysis CFR(s): 483.25(l) 483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by:	F698	Ftag 698 Resident #63: No negative outcomes occurred as a result of this practice. NHA has sent a memo to the dialysis center educating them on the importance of returning communication forms. Residents receiving dialysis have the potential to be affected by this practice.	9/20/19

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F698	Continued From page 242 Based on staff interview, facility document review and clinical record review, it was determined that the facility staff failed to provide dialysis care consistent with professional standards of practice, and the comprehensive person-centered care plan for one of 72 residents in the survey sample, Resident #63. The findings include: The facility staff failed to ensure adequate communication and collaboration for care with Resident #63's hemodialysis (1) center. Resident #63 was admitted to the facility on 2/18/17. Resident #63's diagnoses included but were not limited to end stage renal (kidney) disease, diabetes and history of stroke. Resident #63's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 6/8/19, coded the resident as being cognitively intact. Section O coded Resident #63 as having received dialysis services within the last 14 days. Review of Resident #63's clinical record revealed a physician's order for hemodialysis every Monday, Wednesday and Friday. Resident #63's comprehensive care plan dated 2/18/19 documented, "(Name of Resident #63) is at risk for complications R/T (related to) needs dialysis due to: End Stage Renal Disease, (Sic.) Requires Hemodialysis...Hemodialysis as ordered..." The care plan documented the address and phone number of the dialysis center but failed to document specific information regarding communication with the dialysis center. Review of Resident #63's dialysis communication book (a book that contained	F698	DON or designee will educate licensed nursing staff on completing communication forms, sending the dialysis book with residents, and following up with dialysis centers if communication should not return. DON or designee will audit communication books for residents receiving dialysis during the clinical operations meeting. NHA will educate current dialysis centers being used on the importance of return communication. DON or designee will monitor dialysis books 5 times a week for 1 week, 3 times a week for 2 weeks, weekly for 4 weeks and monthly for 3 months. Any variances will be corrected and additional education or counseling will be provided as needed. Any concerns will be reported to the quality assurance committee monthly until resolved. Continued compliance will be monitored through the facility's quality assurance program. Additional education and monitoring will be initiated for any identified concerns. Completion Date: September 20, 201	

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F698	Continued From page 243 communication forms to be completed by facility staff, sent with the resident to dialysis and returned with documented communication from the dialysis center) revealed multiple communication forms from May 2019 through July 2019. The forms contained a top section that was supposed to be completed by the facility staff. The top section of the forms contained areas for the facility staff to document Resident #63's vital signs, significant changes since the last dialysis session, labs [laboratory tests] drawn since last dialysis session, physical assessment, diet/fluid order and brief summary of intake, activity level, compliance with physician's orders and changes in medication regimen since last dialysis visit. The bottom section of the forms contained areas for the dialysis center staff to document medications given during dialysis, dressing change completion, transfusion complications during dialysis, post dialysis weight/vital signs, labs, changes in medication, food/fluids consumed and next dialysis date/time. Further review of the dialysis communication book failed to reveal evidence that communications forms were completed on 5/22/19, 5/31/19, 6/19/19, 6/21/19, 7/5/19, 7/10/19, 7/12/19, 7/15/19, 7/17/19, 7/19/19, 7/22/19, 7/24/19, 7/26/19, 7/29/19 and 7/31/19. On 8/5/19 at 3:44 p.m., an interview was conducted with RN (registered nurse) #8 regarding the facility process for utilizing Resident #63's dialysis communication book. RN #8 stated the facility staff is supposed to take Resident #63's vital signs and document them at the top of the communication form each morning before the resident goes to dialysis. RN #8 stated the nurses are supposed to document any significant changes on the form	F698		

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F698	Continued From page 244 and attach any labs [laboratory tests] that have been obtained. RN #8 stated after facility staff complete the top portion of the form, and the form is sent to the dialysis center in the dialysis communication book. RN #8 stated staff at the dialysis center is supposed to complete the bottom section of the form and the form is supposed to be returned to the facility after dialysis. RN #8 stated the facility nurses are responsible for checking the communication documented by dialysis center staff at the bottom of the form. RN #8 stated sometimes, the dialysis center staff does not complete the bottom section of the forms, but if Resident #63 returns to the facility and the bottom section of the forms is not completed the facility nurses are supposed to contact the dialysis center to make sure there is not any pertinent information that is needed. RN #8 further stated usually when the nurses call the dialysis center, the dialysis center will fax their patient treatment record form to the facility. RN #8 presented multiple dialysis center patient-treatment, record forms for the months of June 2019 and July 2019. The fax confirmation date on the top of the forms was 8/2/19. RN #8 confirmed the forms were just requested and faxed on 8/2/19. (Note- review of Resident #63's clinical record [nurses' notes] and dialysis communication book failed to reveal documentation of facility communication with the dialysis center on the above dates and failed to reveal any faxed dialysis patient treatment record forms for the above dates). RN #8 stated the dialysis- patient, treatment record form contains information such as Resident #63's blood pressure while receiving dialysis and the weight/amount of fluid removed from Resident #63 during dialysis. When RN #8 was asked why this information was important, RN #8	F698		

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F698	Continued From page 245 stated it was important for facility nurses to know how much fluid was removed because Resident #63 could go into respiratory distress due to too much fluid being removed. RN #8 further stated Resident #63 has a history of bleeding from her dialysis access site. RN #8 stated sometimes the resident returns without a dressing over the site and the dialysis, communication form documents if a dressing was applied at the dialysis center. On 8/6/19 at 11:25 a.m., ASM (administrative staff member) #1 (the administrator), ASM #2 (the regional clinical coordinator) and ASM #3 (the director of nursing) were made aware of the above concern. The facility policy titled, "HEMODIALYSIS-COORDINATION OF SERVICES" documented, "Procedure: 1. Upon receiving an order for hemodialysis, the charge nurse will initiate a communication notebook that will include: -Dialysis Guest Information Sheet -A copy of the current physician's orders, including hemodialysis orders -Current Care plan -Blank Progress Notes -Blank Facility Dialysis Communication -A copy of the guest's advanced directives 2. The Facility Dialysis Communication form will be completed by the charge nurse to be sent with the guest to the dialysis center (Sic.). 3. The Facility Dialysis Communication form may contain the following information: -Change in guest's physical assessment since last exam -Guest's mental/emotional state since last dialysis appointment -Oral intake since last appointment -Activity level since last appointment -New physician orders	F698		

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F698	Continued From page 246 -New labs since last appointment -Most recent vital signs -Most recent weight if weighed between treatments -Guest's compliance with plan of care -Other appropriate comments 4. The communication notebook will be sent with the guest to the dialysis center... 6. The nurse assigned to the guest will review the communication/Progress Notes from the dialysis center and communicate information to the guest's physician, staff caring for the guest, and other ancillary departments as needed..." No further information was presented prior to exit. (1) "When your kidneys are healthy, they clean your blood. They also make hormones that keep your bones strong and your blood healthy. When your kidneys fail, you need treatment to replace the work your kidneys used to do. Unless you have a kidney transplant, you will need a treatment called dialysis. There are two main types of dialysis. Both types filter your blood to rid your body of harmful wastes, extra salt, and water. Hemodialysis uses a machine. It is sometimes called an artificial kidney. You usually go to a special clinic for treatments several times a week." This information was obtained from the website: https://medlineplus.gov/dialysis.html	F698		
F700 SS=E	Bedrails CFR(s): 483.25(n)(1)-(4) 483.25(n) Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and	F700	Ftag 700 Resident #62: No negative outcome occurred as a result of this practice. The physical device evaluation has been completed to reflect entrapment risk and risks vs. benefits have been reviewed and	9/20/19

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F700	Continued From page 247 maintenance of bed rails, including but not limited to the following elements. 483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation. 483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. 483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. 483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, facility document review and clinical record review, it was determined the facility staff failed to implement the bedrail requirements for 18 of 72 residents in the survey sample, Residents #62, #51, #76, #93, #118, #112, #97, #107, #26, #15, #96, #59, #489, #526, #488, #84, #70, and #65. The findings include: 1. The facility staff failed to evidence Resident #62 was assessed for the use of bed rails. Failed to evidence that a review of the risks and benefits for the use of side rails and consent was obtained prior to use. Resident #62 was admitted to the facility on 2/17/17 with a recent readmission on 7/23/19,	F700	consent has been obtained. Resident #51: No negative outcome occurred as a result of this practice. The physical device evaluation has been completed to reflect entrapment risk and risks vs. benefits have been reviewed and consent has been obtained. Resident #76: No negative outcome occurred as a result of this practice. The physical device evaluation has been completed to reflect entrapment risk and risks vs. benefits have been reviewed and consent has been obtained. Resident # 93: No negative outcome occurred as a result of this practice. The physical device evaluation has been completed to reflect entrapment risk and risks vs. benefits have been reviewed and consent has been obtained. Resident #118: Resident no longer resides at the facility. Resident #112: Resident no longer resides at the facility. Resident # 97: Resident no longer resides at the facility. Resident # 107: Resident no longer resides at the facility. Resident #26: Resident no longer resides at the facility. Resident #15: No negative outcome occurred as a result of this practice. The physical device evaluation has been completed to reflect entrapment risk and	

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F700	Continued From page 248 with diagnoses that included but were not limited to: depression, repeated falls, and hepatitis C (inflammation of the liver. similar to hepatitis B. It is spread primarily through blood, though sexual transmission has been described.) (1). The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 6/6/19, coded the resident as scoring a "3" on the BIMS (brief interview for mental status) score, indicating the resident was severely impaired to make daily cognitive decisions. In Section G - Functional Status, the resident was coded as requiring extensive assistance of one staff member for bed mobility. On 7/30/19 at 3:15 p.m., Resident #62 was observed lying in bed; the bed was observed with two half-side rails and half-bed rails were up. The physician order dated, 7/23/19, documented, "Two 1/2 side rails up as an enabler when in bed." The comprehensive care plan, dated, 12/20/18 and revised on 8/2/19, documented in part, "Focus: (Resident #62) has an ADL (activities of daily living) Self Care Performance Deficit and required assistance with ADLs and mobility r/t (related to) impaired balance, limited mobility and glaucoma." The "Interventions" documented in part, "12/20/18 - SIDE RAILS - two half rails up as per physician order for safety during care provisions, to assist with bed mobility. Observe for injury or entrapment related to side railed use. Reposition PRN (as needed) to avoid injury." On 7/31/19 at 12:55 p.m., the assessment of the	F700	risks vs. benefits have been reviewed and consent has been obtained. Resident #96: No negative outcome occurred as a result of this practice. The physical device evaluation has been completed to reflect entrapment risk and risks vs. benefits have been reviewed and consent has been obtained. Resident # 59: No negative outcome occurred as a result of this practice. The physical device evaluation has been completed to reflect entrapment risk and risks vs. benefits have been reviewed and consent has been obtained. Resident #489: Resident no longer resides at the facility. Resident #526: Resident no longer resides at the facility. Resident #488: No negative outcome occurred as a result of this practice. The physical device evaluation has been completed to reflect entrapment risk and risks vs. benefits have been reviewed and consent has been obtained. Resident # 84: No negative outcome occurred as a result of this practice. The physical device evaluation has been completed to reflect entrapment risk and risks vs. benefits have been reviewed and consent has been obtained. Resident # 70: No negative outcome occurred as a result of this practice. The physical device evaluation has been completed to reflect entrapment risk and	

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	495109	A. BUILDING _____ B. WING _____	C 08/07/2019

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F700	Continued From page 249 need for side rails and other alternatives that could be used. The initial assessment of the risk for entrapment and the explanation of risks versus benefits, with informed consent that was obtained for Resident #62, was a requested from administrative staff member (ASM) #1, the administrator. An interview was conducted with RN (registered nurse) #5 on 8/1/19 at 8:44 a.m. When asked about the process for the use of side rails, RN #5 stated, "If someone wants side rails for turning and positioning, we complete a pre-restraint assessment form. We only use half side rails here. We check to see if the rails restrict the resident's movement. Then we put the assessment on paper." When asked where the assessment for the risk of entrapment was located, RN #5 stated she would have to check. RN #5 was asked for the signed informed consent for the use of side rails, that addresses the risks and benefits for the use of side rails and the risk of entrapment. RN #5 stated she would have to check. An interview was conducted with ASM #3, the director of nursing, on 8/1/19 at 8:50 a.m. When asked how the facility assesses residents for the use of side rails, ASM #2 stated, "Maintenance maintains the measurements that are completed. We do a pre-restraint assessment to ensure they are able to use the side rails." When asked where the consent was located that documents the risks and benefits of entrapment for the use of side rails have been obtained from the resident and/or the resident representative, ASM #3 stated, "That's what I'm looking for now. I will get back with you." On 8/1/19 at 8:58 a.m., RN #5 returned to this surveyor and stated, "We have the restraint	F700	risks vs. benefits have been reviewed and consent has been obtained. Resident # 65: No negative outcome occurred as a result of this practice. The physical device evaluation has been completed to reflect entrapment risk and risks vs. benefits have been reviewed and consent has been obtained. Residents with side rails in the facility have the potential to be affected. DON or designee will educate licensed nursing staff on the updated policy/process for bed rails and entrapment, to include physical device evaluation, risk vs. benefit and consent. DON or designee has conducted an audit of current resident beds. The updated physical device evaluation will be completed for every resident, risks vs. benefits will be reviewed and consent will be obtained for current residents. DON or designee will monitor new orders for side rails 5 times a week for 1 week, 3 times a week for 2 weeks, weekly for 4 months, and monthly for 3 months. Any variances will be corrected and additional education or counseling will be provided as needed Any concerns will be reported to the quality assurance committee monthly until resolved. Continued compliance will be monitored	

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F700	Continued From page 250 reduction form and the pre-restraint reduction form. They are the only forms we have at the facility." On 8/2/19 at 1:30 p.m. ASM #1, the administrator, provided a "Pre-Restraint Intervention Evaluation" dated, 8/23/17 for Resident #62. No further documents were provided prior to exit. The policy on the use of bed rails and the risk of entrapment were requested from ASM #1, the administrator on 8/6/19 at 1:50 p.m. The facility presented a policy on 8/6/19 at 4:25 p.m. The policy, "Bed/Mattress/Side rail Spacing" documented in part, "(Name of company) facilities will ensure that all beds are free from areas of possible entrapment which may pose a risk of hazards or serious injury." Review of the policy failed to evidence assessment of the resident and explanation of the risk and benefits or a consent for use of side rail. ASM #1, the administrator, ASM #2, the regional clinical coordinator, and ASM #3, the director of nursing were made aware of the above concern on 8/6/19 at 5:19 p.m. No further information was provided prior to exit. (1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 269. 2. The facility staff failed to evidence Resident #51 was assessed for the use of bed rails. In addition, failed to evidence that a review of the risks and benefits for the use of side rails and	F700	through the facility's quality assurance program. Additional education and monitoring will be initiated for any identified concerns. Completion Date: September 20, 2019	

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F700	Continued From page 251 consent was obtained prior to use. Resident #51 was admitted to the facility on 2/9/19 with diagnoses that included but were not limited to: dementia, high blood pressure, and fractures of the ribs. The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 5/26/19, coded the resident as scoring a "12" on the BIMS (brief interview for mental status) score, indicating the resident was moderately impaired to make daily cognitive decisions. In Section G - Functional Status, the resident was coded as requiring supervision of one staff member for moving in the bed. An interview was conducted with Resident #51 on 7/31/19 at 8:51 a.m. She was in her wheelchair but one-half rail was up on the bed. When asked if she uses the side rail, Resident #51 stated she uses it to get in and out of bed. She only needs one of them. The physician order dated, 2/18/19, documented, "Two 1/2 side rails up as an enabler when in bed." The comprehensive care plan dated, 3/1/19, documented in part, "Focus: (Resident #51) has an ADL self-care performance deficit and requires assistance with ADLs and mobility r/t impaired mobility d/t (due to) fractured ribs." The "Interventions" documented in part, "BED MOBILITY - Resident requires extensive assistance of one staff to reposition and turn in bed. SIDE RAILS - Two half rails up as per physician orders for safety while in bed, to assist with bed mobility. Observe for injury or entrapment related to side rail use. Reposition	F700		

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F700	Continued From page 252 PRN (as needed) to avoid injury." On 7/31/19 at 12:55 p.m., the assessment of the need for side rails and other alternatives that could be used. The initial assessment of the risk for entrapment and the explanation of risks versus benefits, with informed consent that was obtained for Resident #51, was a requested from administrative staff member (ASM) #1, the administrator. On 8/2/19 at 1:30 p.m. ASM #1, the administrator, provided a "Physical Device Evaluation" dated, 2/19/19 for Resident #91. No further documents were provided prior to exit. ASM #1, the administrator, ASM #2, the regional clinical coordinator, and ASM #3, the director of nursing were made aware of the above concern on 8/6/19 at 5:19 p.m. No further information was provided prior to exit. 3. The facility staff failed to evidence Resident #76 was assessed for the use of bed rails. In addition, failed to evidence that a review of the risks and benefits for the use of side rails and consent was obtained prior to use. Resident #76 was admitted to the facility on 6/28/17 with diagnoses that included but were not limited to: stroke, dementia, diabetes and high blood pressure. The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 6/919, coded the resident as scoring a "10" on the BIMS (brief interview for mental status) score, indicating he was moderately impaired to make daily cognitive decisions. In Section G - Functional Status, the	F700		

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F700	Continued From page 253 resident was coded as requiring extensive assistance of one staff member for moving in the bed. Observation was made on 7/31/19 at 11:31 a.m., 8/1/19 at 2:45 p.m. and 8/2/19 at 11:43 a.m., of Resident #76 in his bed with both side rails in the up position. The physician order dated, 12/18/18, documented, "Two 1/2 side rails up as an enabler when in bed every shift." The comprehensive care plan dated, 1/10/19, documented in part, "Focus: (Resident #76) has an ADL self-care performance deficit and requires assistance with ADLs and mobility r/t limited mobility." The "Interventions" documented in part, "BED MOBILITY - Resident requires extensive assistance of two staff to reposition and turn in bed. SIDE RAILS - Two half rails up as per physician orders for safety while in bed, to assist with bed mobility. Observe for injury or entrapment related to side rail use. Reposition PRN (as needed) to avoid injury." On 7/31/19 at 12:55 p.m., the assessment of the need for side rails and other alternatives that could be used. The initial assessment of the risk for entrapment and the explanation of risks versus benefits, with informed consent that was obtained for Resident #76, was a requested from administrative staff member (ASM) #1, the administrator. On 8/2/19 at 1:30 p.m. ASM #1, the administrator, provided a "Physical Device Evaluation" dated, 12/19/18 for Resident #76. No further documents were provided prior to exit.	F700		

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F700	Continued From page 254 ASM #1, the administrator, ASM #2, the regional clinical coordinator, and ASM #3, the director of nursing were made aware of the above concern on 8/6/19 at 5:19 p.m. No further information was provided prior to exit. 4. The facility staff failed to evidence Resident #93 was assessed for the use of bed rails. In addition, failed to evidence that a review of the risks and benefits for the use of side rails and consent was obtained prior to use. Resident #93 was admitted to the facility o7/30/15 with diagnoses that included but were not limited to: high blood pressure, depression and history of falls. The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 6/28/19 coded the resident as scoring a "3" on the BIMS (brief interview for mental status) score, indicating she was severely impaired to make daily cognitive decisions. In Section G - Functional Status, the resident was coded as requiring extensive assistance of one staff member for move in the bed. Observation was made of Resident #93 on 7/30/19 at 4:21 p.m. in her bed. Two half-side rails were observed on the bed in the up position. The physician order dated, 9/15/17, documented, "Two 1/2 side rails up as an enabler when in bed every shift." The comprehensive care plan dated 12/4/18 and	F700		

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F700	Continued From page 255 revised on 3/21/19, documented in part, "Focus: (Resident #93) has an ADL self-care performance deficit and requires assistance with ADLs and mobility r/t muscle weakness, impaired balance, decreased strength, functional mobility." The "Interventions" documented in part, "BED MOBILITY - Resident requires extensive assistance of one staff to reposition and turn in bed. SIDE RAILS - Two half rails up as per physician order for safety while in bed, to assist with bed mobility. Observe for injury or entrapment related to side rail use. Reposition PRN to avoid injury." On 7/31/19 at 12:55 p.m., the assessment of the need for side rails and other alternatives that could be used. The initial assessment of the risk for entrapment and the explanation of risks versus benefits, with informed consent that was obtained for Resident #93, was a requested from administrative staff member (ASM) #1, the administrator. On 8/2/19 at 1:30 p.m. ASM #1, the administrator, provided a "Determination of Device Usage" dated, 7/31/15 for Resident #93. No further documents were provided prior to exit. ASM #1, the administrator, ASM #2, the regional clinical coordinator, and ASM #3, the director of nursing were made aware of the above concern on 8/6/19 at 5:19 p.m. No further information was provided prior to exit. 5. The facility staff failed to evidence Resident #118 was assessed for the use of bed rails. In addition, failed to evidence that a review of the risks and benefits for the use of side rails and	F700		

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F700	Continued From page 256 consent was obtained prior to use. Resident #118 was admitted to the facility on 5/25/19 with diagnoses that included but were not limited to: multiple fractures, dementia, diabetes, and brain hemorrhage. The most recent MDS (Minimum data set) assessment, a significant change assessment, with an assessment reference date of 7/1/19, coded the resident as scoring a "9" on the BIMS (brief interview for mental status) score, indicating the resident was moderately impaired to make daily cognitive decisions. In Section G - Functional Status, the resident was coded as requiring extensive assistance of one staff member for moving in the bed." Observation was made of Resident #118 on 7/30/19 at 4:15 p.m. in her bed with two half-side rails that were both in the up position. The physician order dated, 5/25/19, documented, "Two 1/2 side rails up as an enabler when in bed." The comprehensive care plan dated, 6/6/19, documented in part, "Focus: (Resident #118) has an ADL self-care performance deficit and requires assistance with ADLs and mobility r/t dementia, repeated falls and rib fractures." The "Interventions" documented in part, "BED MOBILITY - Resident requires extensive assistance of one staff to reposition and turn in bed. SIDE RAILS - Two half rails up as per physician order for safety while in bed, to assist with bed mobility. Observe for injury or entrapment related to side rail use. Reposition PRN to avoid injury." On 7/31/19 at 12:55 p.m., the assessment of the	F700		

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F700	Continued From page 257 need for side rails and other alternatives that could be used. The initial assessment of the risk for entrapment and the explanation of risks versus benefits, with informed consent that was obtained for Resident #118, was a requested from administrative staff member (ASM) #1, the administrator. On 8/2/19 at 1:30 p.m. ASM #1, the administrator, provided a "Physical Device Evaluation" form dated 6/25/19 for Resident #118. No further documents were provided prior to exit. ASM #1, the administrator, ASM #2, the regional clinical coordinator, and ASM #3, the director of nursing were made aware of the above concern on 8/6/19 at 5:19 p.m. No further information was provided prior to exit. 6. The facility staff failed to assess Resident #112 for the use of side rails and failed to ensure the risks, benefits were explained, and a signed consent obtained prior to the use of the side rails. Resident #112 was admitted to the facility on 6/28/19 with the diagnoses of but not limited to endometrial cancer, congestive heart failure, heart attack, chronic kidney disease, atrial fibrillation, chronic obstructive pulmonary disease, high blood pressure, diabetes, anxiety, depression, and pulmonary embolism. The admission/5-day MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 7/5/19 coded the resident as being cognitively intact in ability to make daily life decisions. The resident was coded as extensive care for all areas of	F700		

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F700	Continued From page 258 activities of daily living. On 7/30/19 at approximately 11:45 AM, 2:15 PM, and on 7/31/19 at approximately 9:30 PM, observations were made of the resident's room. On each observation she was either not in the room or was in her wheelchair. She was not observed in bed. The bed was noted to have side rails on both sides of the bed in the up position. A review of the clinical record revealed a physician's order dated 6/28/19 for "Two 1/2 (half) side rails up as an enabler when in bed." A review of the comprehensive care plan revealed one dated 6/29/19 for "(Resident #112) has an ADL (activities of daily living) self care performance deficit and requires assistance with ADL's and mobility...." This care plan included the intervention, dated 7/12/19, for "Side Rails: Bilateral half rails up as per physician orders for safety during care provision, to assist with bed mobility. Observe for injury or entrapment related to side rail use. Reposition PRN (as needed) to avoid injury." Further review of the clinical record revealed a "Physical Device Evaluation" form that was completed on 6/28/19. This form documented in section 2, "Bed/Side Rails and Assist Bars: 1. Assist Bar, 2. Full Side Rail, 3. 3/4 Side Rail, 4. 1/2 Side Rail, 5. Both Up, 6. One Up, 7. Not Used." Item 4 and 5 were checked for this resident. Section 4 of this form documented, "Reason for Enabler Device Use: 1. Repositioning/Support, 2. Enable/Increase Bed Mobility, 3. Enhance Mobility, 4. Enable/Increase Independence." All 4 reasons were checked for this resident.	F700		

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F700	Continued From page 259 There was no evidence in the clinical record that an evaluation of risk of entrapment, review risks and benefits and informed consent was obtain prior to the use of bed rails. On 8/6/19 at 8:30 AM in an interview with LPN #3 (Licensed Practical Nurse), when asked if Resident #112 uses the handrails on her bed, LPN #3 stated that she does use them. On 8/6/19 at 8:40 AM, ASM (administrative staff member) #1, the Administrator, were made aware of the findings. No further information was provided. 7. The facility staff failed to assess Resident #97 for the use of side rails and failed to ensure the risks, benefits were explained, and a signed consent obtained prior to the use of the side rails. Resident #97 was admitted to the facility on 6/12/19 with the diagnoses of but not limited to congestive heart failure, stroke, hemiplegia, high blood pressure, diabetes, atrial fibrillation, dysphagia, heart attack, and cardiac defibrillator. The admission/5-day MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 6/19/19 coded the resident as being cognitively intact in ability to make daily life decisions. The resident was coded as extensive care for all areas of activities of daily living. On 7/30/19 at approximately 11:45 AM, 2:15 PM, and on 7/31/19 at approximately 9:30 PM, observations were made of the resident's room. During each observation the resident was either not in the room or was in his wheelchair. He was not observed in bed. The bed was noted with side rails on both sides of the bed in the up	F700		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LAURELS OF UNIVERSITY PARK	2420 PEMBERTON RD RICHMOND, VA 23233

(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) COMPLETE DATE
F700	Continued From page 260 position. A review of the clinical record revealed a physician's order dated 6/12/19 for "Two 1/2 (half) side rails up as an enabler when in bed." A review of the comprehensive care plan revealed one dated 6/25/19 for "(Resident #97) has an ADL (activities of daily living) self care performance deficit and requires assistance with ADL's and mobility...." This care plan included the intervention, dated 6/25/19, for "Side Rails: Bilateral half rails up as per physician orders for safety during care provision, to assist with bed mobility. Observe for injury or entrapment related to side rail use. Reposition PRN (as needed) to avoid injury." Further review of the clinical record revealed a "Physical Device Evaluation" form that was completed on 6/12/19. This form documented in section 2, "Bed/Side Rails and Assist Bars: 1. Assist Bar, 2. Full Side Rail, 3. 3/4 Side Rail, 4. 1/2 Side Rail, 5. Both Up, 6. One Up, 7. Not Used." Item 4 was checked for this resident. Section 4 of this form documented, "Reason for Enabler Device Use: 1. Repositioning/Support, 2. Enable/Increase Bed Mobility, 3. Enhance Mobility, 4. Enable/Increase Independence, (no item 5 was listed) 6. Improves Physical Status, 7. Improves Emotional Status (no item 8 was listed) 9. Able to Participate in Activities, 10. Safety Awareness". All of these reasons were checked for this resident. There was no evidence in the clinical record that an evaluation of risk for entrapment was completed, review risks and benefits and informed consent was obtained prior to the use of bed rails.	F700		

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F700	Continued From page 261 On 8/6/19 at 8:30 AM in an interview with LPN #3 (Licensed Practical Nurse), when asked if Resident #97 uses the handrails on his bed, LPN #3 stated that he does use them. On 8/6/19 at 8:40 AM, ASM (administrative staff member) #1, the Administrator, was made aware of the findings. No further information was provided. 8. The facility staff failed to assess Resident #107 for the use of side rails and failed to ensure the risks, benefits were explained, and a signed consent obtained prior to the use of the side rails. Resident #107 was admitted to the facility on 6/30/19 with the diagnoses of but not limited to multiple rib fractures, tibia fracture, prostate cancer, congestive heart failure, atrial fibrillation, high blood pressure, dementia, dysphagia, glaucoma, and macular degeneration. The admission/5-day MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 7/7/19 coded the resident as being cognitively intact in ability to make daily life decisions. The resident was coded as requiring total care for bathing and extensive assistance for all other areas of activities of daily living. On 7/30/19 at approximately 11:45 AM, 2:15 PM, and on 7/31/19 at approximately 9:30 PM, observations were made of the resident's room. During each observation Resident #107 was either not in the room or was in his wheelchair. He was not observed in bed. Resident #107's bed was observed with side rails on both sides of the bedside in the up position. A review of the clinical record revealed a	F700		

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F700	Continued From page 262 physician's order dated 6/30/19 for "Two 1/2 (half) side rails up as an enabler when in bed." A review of the comprehensive care plan revealed one dated 6/30/19 for "(Resident #107) has an ADL (activities of daily living) self care performance deficit and requires assistance with ADL's and mobility...." This care plan included the intervention, dated 7/12/19, for "Side Rails: Bilateral half rails up as per physician orders for safety during care provision, to assist with bed mobility. Observe for injury or entrapment related to side rail use. Reposition PRN (as needed) to avoid injury." The facility's electronic medical record system contains a form titled "Physical Device Evaluation" which included an assessment for the need and use of side rails. This form was not completed for Resident #107. In addition, there was no evidence in the clinical record an evaluation for risk of entrapment was completed, or a review of the risks and benefits or that informed consent was obtain prior to the use of bed rails. On 8/6/19 at 8:40 AM, ASM (administrative staff member) #1, the Administrator, was made aware of the findings. No further information was provided. 9. The facility failed to assess Resident #26 for the risk of entrapment with the use of bedrails, explain the risks and benefits associated with the use of bedrails, and did not obtain from the resident/resident's representative consent for the use of bedrails. Resident #26 was admitted to the facility on	F700		

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F700	Continued From page 263 4/19/19 with diagnoses that included but were not limited to: vascular dementia without behavioral disturbance (1), diabetes, contracture of right upper arm, and a heart attack. The most recent MDS (minimum data set) assessment, a 30 day Medicare Payment assessment with an ARD (assessment reference date) of 5/6/19, coded the resident as scoring a 3 out of 15 on the BIMS (brief interview for mental status) score, indicating that he has severe cognitive impairment for daily decision making. Resident #26 was coded as requiring extensive assistance from one of more person physical assistance for bed mobility, toileting, and dressing. Resident #26 was coded as being totally dependent on one or more person's physical assistance for transfers, bathing and personal hygiene. Resident #26 was observed in bed with bilateral upper bedrails in the up position on 7/30/19 at 10:15 am, 7/31 9:30 am and 8/1/19 at 8:40 am. The physician orders dated 4/22/19 documented in part, "Two 1/2 padded side rails up as an enabler when in bed every shift for the turning and repositioning". The physical device evaluation dated 4/22/19 documented in part, "Evaluation of bilateral padded 1/2 side rails as enabler devices in use for repositioning / support and to enable/increase bed mobility". The nurses note dated 7/31/19 documented in part, "Bilateral padded 1/2 side rails up, skin tear right wrist due to resident flailing arm". The comprehensive care plan dated 4/25/19, documented in part, "need": (Resident #26)	F700		

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F700	Continued From page 264 "impaired cognitive function related to diagnosis of vascular dementia, and poor safety awareness, impulsivity, ADL (Activities of Daily Living) self-care performance deficit". "The "interventions" documented in part, "two 1/2 rails up as per physician orders for safety while in bed to assist with bed mobility. Observe for injury or entrapment related to side rail use". An interview was conducted on 7/31/19 6:18 pm with Resident #26's responsible representative, who stated, "My dad has a skin tear on his arm, and they said it is from him hitting his arm on the side rails. When did they put them on the bed"? When asked if she was given information about side rails and if consent was obtained to use them, she stated "No". Administrative Staff Member (ASM) #1, the administrator, (ASM) #2, the regional clinical coordinator and (ASM) #3 the director, were made aware of the above concerns on 8/6/19 at 5:17 pm No further information was provided prior to exit. 10. The facility failed to assess Resident # 15 for the risk of entrapment with the use of bedrails, explain the risks and benefits associated with the use of bedrails, and did not obtain from the resident/resident's representative consent for the use of bedrails. Resident # 15 was admitted to the facility on 05/05/2016 with diagnoses that included but were not limited to: muscle weakness, difficulty walking and repeated falls. Resident # 15's most recent MDS (minimum data set), a quarterly assessment with an ARD	F700		

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F700	Continued From page 265 (assessment reference date) of 04/27/19, coded Resident # 15 as scoring an 11 on the brief interview for mental status (BIMS) of a score of 0 - 15, 11 - being moderately impaired of cognition for making daily decisions. Section G coded Resident # 15 as requiring extensive assistance of one staff member for bed mobility. On 07/30/19 at 2:26 p.m., an observation of Resident # 15 revealed she was in bed asleep with upper right and left bed rails raised. The comprehensive care plan for Resident # 15 dated 12/18/2018 documented, "Need. (Resident # 96) has an ADL (activity of daily living) Self Care Performance Deficit and requires assistance with ADL's and mobility r/t (related to): low vision in right eye, difficulty ambulating (walking), fatigue/weakness, limited mobility. Hx (history) of TIA (stroke), Dementia, HTN (high blood pressure). Date Initiated: 12/18/2018." Under "Interventions" it documented, "1/2 (half) rails up bed mobility. Date Initiated: 08/01/2019." Review of the EHR (electronic health record) for Resident # 15 failed to evidence a physical device evaluation dated. Further review of EHR (electronic health record) for Resident # 15 failed to evidence informed consent, risks and benefits and an entrapment assessment for side rail use. On 08/05/19 at 5:10 p.m., ASM (administrative staff member) #1, administrator, ASM # 2, regional clinical coordinator and ASM #3 (director of nursing) were made aware of the above concern. No further information was presented prior to exit.	F700		

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F700	Continued From page 266	F700		

11. The facility failed to assess Resident #96 for the risk of entrapment with the use of bedrails, explain the risks and benefits associated with the use of bedrails, and did not obtain from the resident/resident's representative consent for the use of bedrails.

Resident # 96 was admitted to the facility on 07/04/2019 with diagnoses that included but were not limited to: chronic pain and right knee pain.

Resident # 96's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 07/10/19, coded Resident # 96 as scoring a 14 on the brief interview for mental status (BIMS) of a score of 0 - 15, 15 - being cognitively intact for making daily decisions. Section G coded Resident # 96 as requiring supervision of one staff member for bed mobility.

On 07/30/19 at 4:00 p.m., an observation revealed Resident # 96 was in bed with upper right and left bed rails raised. Resident # 96 stated that the bed rails are up all the time.

On 07/31/19 at 10:20 a.m., an observation revealed Resident # 96 was in bed with upper right and left bed rails raised.

The comprehensive care plan for Resident # 96 dated 12/21/2018 documented, "Need. (Resident # 96) has an ADL (activity of daily living) Self Care Performance Deficit and requires assistance with ADL's and mobility r/t (related to) dx (diagnosis): of MS (multiple sclerosis), chronic pain, limited mobility. Date Initiated: 12/21/2018." Under "Interventions" it

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F700	Continued From page 267 documented, "SIDE RAILS: Two half rails up as per physician orders for safety during care provision, to assist with bed mobility, Observe for injury or entrapment related to side rail use. Reposition PRN (as needed) to avoid injury. Date Initiated: 12/21/2018." The POS (physician order sheet) for Resident # 96 dated August 2019 documented, "Two 1/2 (half) side rails up as an enabler when in bed. Order Date 05/29/2019." On 7/31/19 at approximately 1:00 p.m., a request was made to ASM (administrative staff member) # 1 the administrator, via a list of residents requesting required documentation for the use of side rails for Resident #96. On 8/1/19 at approximately 11:30 a.m., a physical device evaluation dated 09/05/2018 for Resident # 96 was received documenting two-half side rails. The document failed to evidence informed consent, risks and benefits and entrapment assessment were completed prior to the use of side rails for Resident #96. On 08/05/19 at 5:10 p.m., ASM (administrative staff member) #1, administrator, ASM # 2, regional clinical coordinator and ASM #3 (director of nursing) were made aware of the above concern. No further information was presented prior to exit. 12. The facility failed to assess Resident #59 for the risk of entrapment with the use of bedrails, explain the risks and benefits associated with the use of bedrails, and did not obtain from the resident/resident's representative consent for the use of bedrails.	F700		

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F700	Continued From page 268 Resident # 59 was admitted to the facility on 05/22/2015 with diagnoses that included but were not limited to: muscle weakness and difficulty walking. Resident # 59's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 06/09/19, coded Resident # 59 as scoring a eight on the brief interview for mental status (BIMS) of a score of 0 - 15, eight - being moderately impaired of cognition for making daily decisions. Section G coded Resident # 59 as requiring extensive assistance of one staff member for bed mobility. On 07/30/19 at 5:05 p.m., an observation of Resident # 59 revealed she was in bed with upper right and left bed rails raised. The comprehensive care plan for Resident # 59 dated 12/28/2018 documented, "Need. (Resident # 59) has an ADL (activity of daily living) Self Care Performance Deficit and requires assistance with ADL's and mobility r/t (related to) Impaired balance, Limited Mobility. Date Initiated: 12/28/2018." Under "Interventions" it documented, "SIDE RAILS: Two half rails up as per physician orders for safety during care provision, to assist with bed mobility. Observe for injury or entrapment related to side rail use. Reposition PRN (as needed) to avoid injury. Date Initiated: 12/28/2018." The POS (physician order sheet) for Resident # 59 dated August 2019 documented, "Two 1/2 (half) side rails up as an enabler when in bed every shift for safety. Order Date 09/16/2017. Start Date: 09/16/2017."	F700		

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F700	Continued From page 269 On 7/31/19 at approximately 1:00 p.m., a request was made to ASM (administrative staff member) # 1 the administrator, via a list of residents requesting required documentation for the use of side rails for Resident #59. Review of the EHR (electronic health record) for Resident # 59 failed to evidence a physical device evaluation was completed. Further review of EHR (electronic health record) for Resident # 59 failed to evidence informed consent was obtained, risks and benefits were reviewed with the resident or responsible party and there was no entrapment assessment for bed rail use. On 08/05/19 at 5:10 p.m., ASM (administrative staff member) #1, administrator, ASM # 2, regional clinical coordinator and ASM #3 (director of nursing) were made aware of the above concern. No further information was presented prior to exit. 13. The facility staff failed to evidence an assessment for the risk of entrapment, review the risks and benefits with the resident and/or representative, and failed to ensure obtain informed consent prior to the use of bed rails for Resident #489. Resident #489 was admitted to the facility on 7/25/19, with the diagnoses that included but not limited to high blood pressure, chronic obstructive pulmonary disease, and bipolar disorder. Due to the recent admission, the MDS (Minimum Data Set) had not yet been completed. According to the "Nursing	F700		

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F700	Continued From page 270 Admission" note dated 7/25/19, Resident #489 was alert and oriented to time, place, and person. According to the "Care Plan" dated 7/25/19, Resident #489 required assistance with ADL's (Activities of Daily Living) and mobility. On 7/30/19 at 11:59 PM, 4:15 PM, and 4:44 PM, Resident #489 was observed in bed. Her bed was noted to have two upper side rails (one on each side) and the bed rails were in the up position during each observation. On 7/30/19 at 4:49 PM, an interview with Resident #489 was conducted. When Resident #489 was asked if the facility discussed the risks and benefits for the use of bed rails, she stated, "They discussed it." Resident #489 was asked if she signed an informed consent prior to the use of bed rails, she stated, "I signed a lot of papers." A review of the clinical record revealed a physician's order dated 7/25/19, which documented in part: "...Two half side rails up as an enabler when in bed ..." A review of the clinical record revealed a care plan dated 7/25/19, which documented in part, "...is at risk for complications due to they require the use of ...enabler, restraint enabler ..." Continued review of the clinical record revealed a physical device evaluation dated 7/25/19, which documented in part, the use of bilateral half side rails as an enabler for repositioning and bed mobility. Further review of the clinical record failed to reveal any documented evidence that the risk and benefits for the use of bed rails was discussed with the resident and/or	F700		

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F700	Continued From page 271 representative; risk assessment for entrapment; or any evidence an informed consent was obtained for the use of the bed rails for Resident #489. On 8/6/19 at 8:36 AM, an interview with LPN (Licensed Practical Nurse) #3 was conducted. When LPN #3 was asked if Resident #489 uses the bed rails, she stated, "I have seen her use the bed rails." On 8/2/19 at 1:48 PM, ASM (administrative staff member) #1, the Administrator, ASM #3, the Director of Nursing, and ASM #2, the Regional Clinical Coordinator, were made aware of the findings. No further information was provided by the end of the survey. 14. The facility staff failed to evidence an assessment for the risk of entrapment, review the risks and benefits with the resident and/or representative, and obtain informed consent prior to the presence of and use of bed rails for Resident #526. Resident #526 was admitted to the facility on 7/26/19 diagnoses include but are not limited to left hip fracture, lung cancer, high blood pressure and pacemaker. Due to the recent admission, the MDS (Minimum Data Set) had not yet been completed. According the "Nursing Admission" note dated 7/26/19, Resident #526 was alert and oriented to time, place, and person; requires extensive assistance for toileting; total care for transfers and bed mobility; and continent of bladder and bowel. During observations on 7/30/19 at 4:00 PM, and	F700		

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F700	Continued From page 272 7/31/19 at 3:44 PM. Resident #526 was observed in bed with bed rails located on both sides of the upper portion of the resident's bed, in the up position. A review of the clinical record revealed a physician's order dated 7/26/19, which documented in part, " ...Two half side rails up as an enabler when in bed ..." A review of the clinical record revealed a care plan dated 7/27/19, which documented in part, " ...is at risk for complications due to they require the use of ...enabler, restraint enabler ..." A review of the clinical record revealed a physical device evaluation dated 7/26/19, which documented in part for the use of bilateral half side rails as an enabler for repositioning and bed mobility. Further review of the clinical record failed to reveal any documented evidence that the risk and benefits for the use of bed rails was discussed with the resident and/or representative; risk assessment for entrapment; or any evidence an informed consent was obtained for the use of the bed rails for Resident #526. On 8/6/19 at 8:36 AM, an interview with LPN (Licensed Practical Nurse) #3 was conducted. When LPN #3 was asked if Resident #526 uses the bed rails, she stated, "I not sure if he uses the bed rails." On 8/2/19 at 1:48 PM, ASM (administrative staff member) #1, the Administrator, ASM #3, the Director of Nursing, and ASM #2, the Regional Clinical Coordinator, were made aware of the findings.	F700		

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F700	Continued From page 273 No further information was provided by the end of the survey. 15. The facility staff failed evidence an assessment for the risk of entrapment, review the risks and benefits with the resident and/or representative, and obtain informed consent prior to the presence of and use of bed rails for Resident #488. Resident #488 was admitted to the facility on 7/17/19 with the diagnoses that include but not limited to, multiple sclerosis (1), high blood pressure, and immobility syndrome (paraplegic) (2). Due to the recent admission, the MDS (Minimum Data Set) had not yet been completed. According to the "Nursing Admission" note dated 7/22/19, Resident #488 was alert and oriented to time, place, and person; requires total care and is incontinent of bladder and bowel. On 7/30/19 at 12:27 PM, 4:51 PM, and 7/31/19 at 9:19 AM, Resident #488 was observed in bed with two upper side rails (one on each side) in the up position, at each observation. On 7/30/19 at 4:49 PM, an interview with Resident #488 was conducted. When Resident #488 was asked if the facility discussed the risks and benefits for the use of bed rails, she stated, "They discussed it." When Resident #488 was asked if she signed an informed consent prior to the use of bed rails, she stated, "I do not know if I did." A review of the clinical record revealed a physician's order dated 7/17/19, which documented in part, "...Two half side rails up as	F700		

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F700	Continued From page 274 an enabler when in bed ..." A review of the clinical record revealed a care plan dated 7/17/19, which documented in part requiring assistance with bed mobility. However, the care plan did not address the use of side rails. A review of the clinical record revealed a physical device evaluation dated 7/17/19, which documented in part the use of bilateral half side rails as an enabler for repositioning and bed mobility. Further review of the clinical record failed to reveal any evidence that a risk and benefits for the use of bed rails was discussed with Resident #488 and/or the representative; risk assessment for entrapment; or any evidence an informed consent was obtained for the use of the bed rails for Resident #488. On 8/6/19 at 8:36 AM, an interview with LPN (Licensed Practical Nurse) #3 was conducted. When LPN #3 was asked if Resident #488 uses the bed rails, she stated, "I have seen her use the bed rails." On 8/2/19 at 1:48 PM, ASM (administrative staff member) #1, the Administrator, ASM #3, the Director of Nursing, and ASM #2, the Regional Clinical Coordinator, were made aware of the findings. No further information was provided by the end of the survey. References: (1). Multiple sclerosis: A nervous system disease that affects your brain and spinal cord.	F700		

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F700	Continued From page 275 This information was obtained from the following website: https://medlineplus.gov/multiplesclerosis.html (2) Paraplegic: Paralysis is the loss of muscle function in part of your body. This information was obtained from the following website: https://medlineplus.gov/paralysis.html 16. The facility staff failed to evidence an assessment for the risk of entrapment, review the risks and benefits with the resident and/or representative, and obtain informed consent prior to the use of bed rails for Resident #84. Resident #84 was admitted to the facility on 5/15/19 with the diagnoses that included but not limited to osteomyelitis (1), hermansky-pudlak syndrome (2), multiple sclerosis (3), major depressive disorder, and high blood pressure. The most recent MDS (Minimum Data Set), a 14-day assessment, with an ARD (Assessment reference date) of 6/27/19, coded the resident as scoring a 13 out of 15 on the BIMS (Brief Interview for Mental Status) score, indicating the Resident had no cognitive impairment for daily decision making. The resident was coded as requiring limited assistance for eating, extensive assistance for bed mobility, hygiene, dressing, and toileting, and total care for transfers and bathing. On 7/30/19 at 12:20 PM and 3:43 PM, and 7/31/19 at 2:15 PM, Resident #84 was observed in his bed. His bed was noted to have two upper side rails (one on each side) and the bed rails were up at each observation. A review of the clinical record revealed a physician's order dated 5/16/19, which	F700		

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F700	Continued From page 276 documented in part, "...Two half side rails up as an enabler when in bed ..." A review of the clinical record revealed a care plan dated 5/24/19, which documented in part, " ...(Resident #84's name) has an ADL (Activities of Daily Living) Self Care Performance Deficit and requires assistance with ADL's and mobility ...Interventions: Side Rails: Two half rails up as per physician orders ..." Further review of the clinical record failed to reveal any documented evidence that the risk and benefits for the use of bed rails was discussed with Resident #84 and/or the representative; risk assessment for entrapment; or any evidence of an informed consent was obtained for the use of the bed rails for Resident #84. On 8/6/19 at 8:36 AM, an interview with LPN (Licensed Practical Nurse) #3 was conducted. When LPN #3 was asked if Resident #84 uses the bed rails, she stated, "I have seen him use the bed rails." On 8/2/19 at 1:48 PM, ASM (administrative staff member) #1, the Administrator, ASM #3, the Director of Nursing, and ASM #2, the Regional Clinical Coordinator, were made aware of the findings. No further information was provided by the end of the survey. References: (1). Osteomyelitis: Osteomyelitis is a bone infection. It is mainly caused by bacteria or other germs. This information was obtained from the following website: https://medlineplus.	F700		

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F700	Continued From page 277 gov/ency/article/000437.htm (2). Hermansky-Pudlak Syndrome: A disorder characterized by a condition called oculocutaneous albinism, which causes abnormally light coloring (pigmentation) of the skin, hair, and eyes. This information was obtained from the following website: https://ghr.nlm.nih.gov/condition/hermansky-pudlak-syndrome (3). Multiple sclerosis: A nervous system disease that affects your brain and spinal cord. This information was obtained from the following website: https://medlineplus.gov/multiplesclerosis.html 17. The facility failed to assess Resident #70 for the risk of entrapment with the use of bedrails, explain the risks and benefits associated with the use of bedrails, and did not obtain from the resident/resident's representative consent for the use of bedrails. Resident # 70 was admitted to the facility 12/06/2018 with diagnoses, that included but were not limited to cerebral infarction (1), and muscle weakness (generalized). Resident # 70's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 06/15/19, coded Resident # 70 as scoring a 0 (zero) on the staff assessment for mental status (BIMS) of a score of 0 - 15, 0-being severely impaired for making daily decisions. Resident # 70 was coded as requiring extensive of one staff member for bed mobility. On 7/30/19 at 2:04 p.m. and 07/30/19 at 4:37 p.m., Resident #70 was observed in bed with	F700		

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F700	Continued From page 278 bilateral upper half side rails up on the bed Additional observations on 7/31/19 at 8:34 a.m. and 10:35 a.m. revealed Resident #70 was in bed with bilateral upper half side rails up on the bed. The comprehensive care plan documented, "[name of resident] has an ADL (activities of daily living) self-care performance deficit and requires assistance with ADL's and mobility r/t (related to): limited mobility, recent CVA (stroke), right sided weakness. Date Initiated 12/19/2018. Revision on 05/09/2019." Under "Interventions" it is documented, "Side Rails: Two half rails up as per physician orders for safety while in bed, to assist with bed mobility. Observe for injury or entrapment related to side rail use. Reposition PRN (as needed) to avoid injury. Date Initiated 05/09/2019. Revision on 05/09/2019." On 7/31/19 at approximately 1:00 p.m., a request was made to ASM (administrative staff member) # 1 the administrator, via a list of residents requesting the required documentation for the use of side rails for Resident #70. On 8/1/19 at approximately 11:30 a.m., a physical device evaluation dated 05/08/2018 for Resident # 70 was received documenting one-half side rails. The document failed to evidence informed consent was obtained, risks and benefits explained and an entrapment assessment was completed. On 08/02/19 at approximately 2:00 p.m., ASM (administrative staff member) # 1, the administrator, ASM # 2, regional clinical coordinator and ASM # 3, director of nursing were made aware of the findings.	F700		

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F700	Continued From page 279 No further information was provided prior to exit. References: 1. Cerebral infarction: A stroke occurs when blood flow to a part of the brain stops. A stroke is sometimes called a "brain attack." This information was obtained from the website: https://medlineplus.gov/ency/article/000726.htm. 18. The facility failed to assess Resident #65 for the risk of entrapment with the use of bedrails, explain the risks and benefits associated with the use of bedrails, and did not obtain from the resident/resident's representative consent for the use of bedrails. Resident # 65 was admitted to the facility on 07/20/2015, with a readmission on 10/24/2016 with diagnoses that included but were not limited to fracture of unspecified part of neck of left femur (1), muscle weakness (2), and essential hypertension (3). Resident # 65's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 06/15/19, coded Resident # 65 as scoring a 3 (three) on the staff assessment for mental status of a score of 0 - 3, 3- being severely impaired for making daily decisions. Resident # 65 was coded as requiring extensive assistance of one staff member for bed mobility. On 7/30/19 at 2:33 p.m. and 07/30/19 at 4:35 p. m. revealed Resident # 65 in bed with bilateral upper half side rails in the up position on the bed. On 7/31/19 at 8:21 a.m. and 10:37 a.m. revealed Resident # 65 in bed with bilateral upper half side rails in the up position on the bed.	F700		

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F700	Continued From page 280 The comprehensive care plan "ADL (activities of daily living) Pref (preferences): Requires assistance with ADL's r/t (related to) impaired mobility d/t (due to) dx (diagnosis) of muscle weakness, h/o (history of) fracture of part of next [sic] of femur, htn (high blood pressure), dementia (4). Meds (medications) crushed as tolerated by the guest. Date Initiated: 12/27/2017 Revision Date: 06/07/2019." Under "Interventions" it documented, "Provide appropriate assistive devices as needed: w/c (wheelchair), Two 1/2 (half) SR (side rail). Date Initiated: 04/13/2018." On 7/31/19 at approximately 1:00 p.m., a request was made to ASM (administrative staff member) # 1 the administrator, via a list of residents requesting required documentation for the use of side rails for Resident # 65. On 8/1/19 at approximately 11:30 a.m., a physical device evaluation for Resident # 65 was received documenting one-half side rails. The document failed to evidence informed consent was obtained, risks and benefits and entrapment assessment were completed. On 08/02/19 at approximately 2:00 p.m., ASM (administrative staff member) # 1, the administrator, ASM # 2, regional clinical coordinator and ASM # 3, director of nursing were made aware of the findings. No further information was provided prior to exit. References: 1. Femur fracture: You had a fracture (break) in the femur in your leg. It is also called the thighbone. This information was obtained from the website: https://medlineplus.	F700		

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F700	Continued From page 281 gov/ency/patientinstructions/000166.htm. 2. Muscle weakness: Weakness is reduced strength in one or more muscles. This information was obtained from the website: https://medlineplus.gov/ency/article/003174.htm 3. Hypertension - High blood pressure. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/highbloodpressure.html. 4. Dementia: A loss of brain function that occurs with certain diseases. It affects memory, thinking, language, judgment, and behavior. This information was obtained from the website: https://medlineplus.gov/ency/article/000739.htm	F700		
F755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) 483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in 483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. 483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. 483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-	F755	F755 Resident # 338: Resident no longer resides in the facility. Resident # 93: No negative outcome occurred from this practice. The medication is available at the facility. All current residents have the potential to be affected. DON or designee will educate the consulting pharmacist on monitoring Coumadin and providing recommendations to the facility. Education will also be provided to licensed	9/20/19

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F755	Continued From page 282 483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. 483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and 483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, it was determined that the facility staff failed to provide pharmacy services for two of 72 residents in the survey sample, Residents #338 and #93. The consulting pharmacist failed to identify the lack of monitoring for Resident #338's use of the high-risk medication Coumadin (1), and facility staff failed to ensure all of Resident #93's physician prescribed medications were available for administration on 4/2/19, 4/3/19 and 4/4/19. The findings include: 1. The consulting pharmacist failed to provide adequate monitoring for Resident #338's use of the high-risk medication Coumadin [1]. Resident #338 was admitted to the facility on 6/29/18. Resident #338's diagnoses included but were not limited to revision of left total knee removal, asthma and high blood pressure. Resident #338's most recent MDS (minimum data set) (prior to discharge), a 14 day Medicare assessment with an ARD (assessment	F755	nursing staff on the process of obtaining medications timely. Medication Regimen review was conducted by the consulting pharmacist for currents residents on Coumadin. A review of the Omnicell contents was conducted for potential medication additions. DON or designee will conduct an audit on pharmacy reviews for residents receiving Coumadin. A MAR to cart audit will be conducted to identify any medications that are not available. Nursing administration will review pharmacy recommendations and will monitor MARs 5 days a week for 1 week, 3 days a week for 2 weeks, weekly for 4 weeks, and monthly for 3 months. Any variances will be corrected and additional education or counseling will be provided as needed. Any concerns will be reported to the quality assurance committee monthly until resolved. Continued compliance will be monitored through the facility quality assurance program. Additional education and monitoring will be initiated for any identified concerns. Completion Date: September 20, 2019	

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F755	Continued From page 283 reference date) of 7/13/18, coded the resident as being cognitively intact. Section N coded Resident #338 as having received an anticoagulant medication seven out of the last seven days. Review of Resident #338's hospital record prior to discharge to the facility revealed Coumadin was initiated during the resident's hospitalization for dvt (deep vein thrombosis [2]) prophylaxis. Further review of the hospital record revealed a PT/INR (prothrombin time/international normalized ratio [3]) of 24.1/2.4 on 6/29/18. A hospital pharmacist note dated 6/29/18 documented, "Warfarin (Coumadin) dosing- Day #5 Consult provided for this 77 y.o. (year old) female to manage warfarin for VTE (sic) prophylaxis s/p (status post) orthopedic surgery. INR Goal: 1.7-2.2. Drugs that may increase INR: Ceftriaxone [5]. Drugs that may decrease INR: None. Other current anticoagulants/drugs that may increase bleeding risk: NSAIDs (nonsteroidal anti-inflammatory drugs) [6]. Risk factors: > (greater than) 65. Daily INR ordered: Yes... Date INR Dose 6/15 1.0 6/25 4mg (milligrams) 6/26 1.0 mg 6/27 2.8 HOLD 6/28 2.1 2 mg 6/29 2.4 Hold Assessment/Plan: Will hold warfarin today for INR above goal. Pharmacy will continue to monitor daily and adjust therapy as indicated." Review of Resident #338's discharge orders from the hospital and documented as being verified by a facility nurse with the on-call physician for ASM (administrative staff member) #5 (Resident #338's facility physician) on	F755		

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	495109	A. BUILDING _____ B. WING _____	C 08/07/2019

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F755	Continued From page 284 6/29/18 documented an order for warfarin (Coumadin) 2 mg- one tablet by mouth daily for dvt prevention. Further review of the discharge orders verified by the facility on-call physician failed to reveal any orders for a PT/INR or any orders for the monitoring of adverse outcomes. A physician's order dated 6/29/18 documented an order for Coumadin- 2 mg by mouth in the evening for DVT prophylaxis. Review of Resident #338's June 2018 and July 2018 MARs (medication administration records) revealed the resident was administered 2 mg of Coumadin as prescribed by the physician from 7/1/19 through 7/22/19. Resident #338's comprehensive care plan dated 7/11/18 documented, " BLEED101: At risk for abnormal bleeding R/T (related to) anticoagulant use...Interventions: Administer medications as ordered...Observe for abnormal s/sx (signs/symptoms) of bleeding. i.e. Bruising, bleeding gums, petechiae (tiny red spots caused by bleeding into the skin), nosebleeds, hematuria (bloody urine), headaches, back of abdominal pain, decrease blood pressure or pulse, occult blood in the stool, etc. Obtain labs as ordered. Report abnormal findings to physician. Report all abnormal findings to physician..." The care plan failed to document information regarding the pharmacist's responsibilities. Further review of Resident #338's clinical record (including nurses' notes, NP (nurse practitioner) notes and physician notes from date of admission to date of discharge) revealed no documentation of monitoring for the prescribed use of Coumadin. The physician note dated 7/2/18 failed to document information regarding Coumadin or monitoring for the medication. The	F755		

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F755	Continued From page 285 NP notes dated 7/3/18, 7/10/18, 7/11/18, 7/12/18, 7/16/18, 7/17/18, 7/18/18, 7/19/18 and 7/20/18 documented information regarding, "Pertinent lab results" but failed to document any information regarding PT/INRs and Coumadin monitoring. The notes further documented, "On Coumadin therapy for DVT prophylaxis..." but failed to document any information regarding the monitoring of Coumadin. Review of notes documented by the pharmacist on 7/2/18 and 7/21/18 revealed the pharmacist reviewed Resident #338's clinical record on those dates. The notes documented, "This resident's medical record including electronic documentation was reviewed on this date. [X] Based upon the information available at the time of the review, and assuming the accuracy and completeness of such information, it is my professional judgement that at such time, the resident's medication regimen contained no new irregularities (as defined in SOM (state operations manual) Appendix PP 483.60 (c)). For purposes of the foregoing statement, the term 'irregularity' means an event or circumstance that is substantially inconsistent with customary, accepted clinical approaches to providing pharmaceutical products and services, or that could reasonably be expected to impede or interfere with the achievement of intended or reasonably expected outcomes." The notes failed to document any information regarding Resident #338's use of Coumadin or monitoring for the medication. A nurse's note dated 7/22/18 at 11:46 p.m. documented, "It was reported that guest has blood stain on bed linen. Bright red blood observed on linen unable to determine if vaginal bleed. Trace bright red blood on washcloth after pericare. Guest has + (positive) bowel sounds	F755		

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F755	Continued From page 286 which are hyperactive in all 4 quadrants." A NP (nurse practitioner) note dated 7/23/18 at 8:30 a.m. documented, "CC (Chief Complaint): blood in stool. HPI (History of Present Illness): ATSP (Asked to See Patient) for blood in stool. Patient reports bright red blood per rectum on several occasions over the weekend. States that she has had blood on her pad and bed. Endorses abdominal pain and burning, diarrhea, and nausea. Unsure if there was blood in the toilet with BM (bowel movement) this morning, was unable to see. Has tried Zofran (6) and pain medication over the weekend with no relief...A/P (Assessment/Plan) GI (gastrointestinal) bleeding: referred to ER (emergency room)..." Review of hospital records revealed Resident #338's INR* was 11.8 on 7/23/18. The resident was administered Vitamin K [8] and underwent a blood transfusion on 7/24/18. *"Prothrombin time (PT) is a blood test that measures the time it takes for the liquid portion (plasma) of your blood to clot." "PT is measured in seconds. Most of the time, results are given as what is called INR (international normalized ratio)." "The most common reason to perform this test is to monitor your levels when you are taking a blood-thinning medicine called warfarin [Coumadin]. You are likely taking this medicine to prevent blood clots. Normal Results: PT is measured in seconds. Most of the time, results are given as what is called INR (international normalized ratio). If you are taking warfarin to prevent blood clots, your provider will most likely, choose to keep your INR between 2.0 and 3.0." [3] On 7/31/19 at 2:36 p.m., an interview was	F755		

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F755	Continued From page 287 conducted with ASM (administrative staff member) #5 (Resident #338's physician at the facility). ASM #5 was asked about the process for Coumadin monitoring for a resident newly admitted to the facility. ASM #5 stated the process depends on the orders provided by the hospital. ASM #5 stated the hospital usually specifies the next date a PT/INR should be obtained and that order should be followed. ASM #5 was asked what should be done if the hospital does not provide an order for a PT/INR. ASM #5 stated usually she would review the resident's chart, find out the last date a PT/INR was checked and order for a PT/INR to be checked within the next few days. ASM #5 stated she likes to have a baseline PT/INR and the value of that PT/INR will determine when the next one should be done. ASM #5 was asked why Coumadin must be monitored. ASM #5 stated Coumadin (levels) could quickly become out of control because the medication can variably react with food and other medications. ASM #5 stated this is why the medication has to be monitored. ASM #5 was asked how often PT/INRs should be obtained to monitor Coumadin and stated that depends on the patient and other variables. On 8/1/19 at 1:36 p.m., a telephone interview was conducted with ASM #8 (the consulting pharmacist), regarding the pharmacy process for Coumadin monitoring. ASM #8 stated he typically reviews the medications prescribed for a newly admitted resident within three days of admission and then monthly. ASM #8 was asked if he identifies whether a PT/INR has been obtained for residents receiving Coumadin. ASM #8 stated usually residents are admitted from the hospital with a PT/INR order and sometimes he completes his medication review before the facility physician evaluates the	F755		

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F755	Continued From page 288 resident. ASM #8 was asked if he noticed that a PT/INR had not been obtained for Resident #338 during her stay at the facility. ASM #8 stated the resident's INR was stable at the hospital on 6/28/18 so he would have reviewed for the need for a PT/INR during his monthly review. ASM #8 stated a PT/INR would not have been due until 7/24/18. When asked why, ASM #8 stated monthly monitoring of PT/INRs was a common clinical practice. ASM #8 was asked to provide/fax the reference for the common clinical practice referred to for review. On 8/1/19 at 2:25 p.m., ASM #1 (the administrator) provided a fax from ASM #8. The fax documented, "Comments: See below verbiage for warfarin/anticoagulant monitoring references: Please ensure that the INR was obtained, communicating the result to the prescriber and documenting in the medical record as soon as it becomes available. Rationale for Recommendation; Continuous appropriate INR and clinical monitoring of warfarin therapy is required to avoid preventable events (e.g. embolism [blood clot], bruising, bleeding). References: 1) Coumadin prescribing information. Princeton, NJ: Bristol-Myers Squibb Company. 2017 Aug. 2) Gurwitz JH et al. The safety of warfarin therapy in the nursing home setting. The Am J Med. 2007; 120:539-544." On 8/2/19 at 12:55 p.m., another telephone interview was conducted with ASM #8 (the consulting pharmacist). ASM #8 was made aware of the completed a medication review for Resident #338 on 7/21/18 and was asked why he did not complete a review of the resident's Coumadin monitoring. ASM #8 stated the computer software notifies him regarding a needed review one month after the last INR entered into the software. ASM #8 stated if the	F755		

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F755	Continued From page 289 last INR was obtained in the hospital and he entered that INR into the software, then the software would not flag for him to complete a review for an INR need until one month after the resident is admitted to the facility. ASM #8 stated he completes the review after the computer software flags for him to do so. On 8/6/19 at 11:25 a.m., ASM (administrative staff member) #1 (the administrator), ASM #2 (the regional clinical coordinator) and ASM #3 (the director of nursing) were made aware of the above concern. The facility pharmacy policy titled, "9.0 Pharmacy Consultant Services" documented, "Procedure: 1. Facility should notify Pharmacy of each new resident admitted to Facility. Facility should identify whether the resident is expected to remain in Facility for less than thirty (30) days. 2. Facility should provide an opportunity for entrance and exit interviews between Pharmacy and Director of Nursing, Administrator, or designee. 3. Facility should provide Pharmacy with adequate work space, access to the residents' medical records (including electronic health records, if used), ability to enter documentation/progress notes in the resident's medical record (including electronic health records), an appropriate environment for resident and family interviews, and important resident information that may include, but is not limited to: 3.1 Current census; 3.2 Residents with a recent change in condition; 3.3 Residents who were admitted for a short stay; 3.4 Residents with recent infection; 3.5 Residents who have fallen; 3.6 Residents with unexpected weight loss; 3.7 Residents who are due for care planning..."	F755		

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F755	Continued From page 290 The policy failed to document information regarding Coumadin monitoring. No further information was presented prior to exit. *"Warfarin (Coumadin) can cause major or fatal bleeding. Regularly monitor INR in all patients." This information was obtained from the reference: Nursing 2016 Drug Handbook (Wolters Kluwer, 2016, p.1495) Black Box Warning [1] "Warfarin (Coumadin) is used to prevent blood clots from forming or growing larger in your blood and blood vessels. It is prescribed for people with certain types of irregular heartbeat, people with prosthetic (replacement or mechanical) heart valves, and people who have suffered a heart attack. Warfarin is also used to treat or prevent venous thrombosis (swelling and blood clot in a vein) and pulmonary embolism (a blood clot in the lung). Warfarin is in a class of medications called anticoagulants ('blood thinners'). It works by decreasing the clotting ability of the blood." This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a682277.html [2] "Deep vein thrombosis, or DVT, is a blood clot that forms in a vein deep in the body. Most deep vein clots occur in the lower leg or thigh. If the vein swells, the condition is called thrombophlebitis. A deep vein thrombosis can break loose and cause a serious problem in the lung, called a pulmonary embolism." This information was obtained from the website: https://vsearch.nlm.nih.gov/vivisimo/cgi-bin/query-meta?v%3Aproject=medlineplus&v%3Asources	F755		

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F755	Continued From page 291 137988019.2081124811.1565615930-1667741437.1550160688 [3] "Prothrombin time (PT) is a blood test that measures the time it takes for the liquid portion (plasma) of your blood to clot." "PT is measured in seconds. Most of the time, results are given as what is called INR (international normalized ratio)." "The most common reason to perform this test is to monitor your levels when you are taking a blood-thinning medicine called warfarin. You are likely taking this medicine to prevent blood clots. Normal Results: PT is measured in seconds. Most of the time, results are given as what is called INR (international normalized ratio). If you are taking warfarin to prevent blood clots, your provider will most likely, choose to keep your INR between 2.0 and 3.0." This information was obtained from the website: https://vsearch.nlm.nih.gov/vivisimo/cgi-bin/query-meta?v%3aproject=medlineplus&v%3asources=medlineplus-bundle&query=laboratory%20tests%20for%20PT%20calculation%20of%20INR& [4] Black Box Warning [A boxed warning is the strongest warning that the FDA (Food and Drug Administration) requires, and signifies that medical studies indicate that the drug carries significant serious or even life-threatening adverse effects]: BLEEDING RISK: COUMADIN can cause major or fatal bleeding. Perform regular monitoring of INR [international normalized ratio - a laboratory blood test that measures how long it takes for blood to clot [3]] in all treated patients. [3] [5] Ceftriaxone is used to treat infections. This information was obtained from the website:	F755		

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F755	Continued From page 292 html [6] "NSAIDs (nonsteroidal anti-inflammatory drugs) are some of the most commonly used pain medicines in adults." This information was obtained from the website: https://www.rheumatology.org/I-Am-A/Patient-Caregiver/Treatments/NSAIDs [7] Zofran is used to prevent nausea. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a601209.html [8] "Vitamins are substances that your body needs to grow and develop normally. Vitamin K helps your body by making proteins for healthy bones and tissues. It also makes proteins for blood clotting. If you don't have enough vitamin K, you may bleed too much." Reversal of COUMADIN anticoagulation may be obtained by discontinuing COUMADIN therapy and, if necessary, by administration of oral or parenteral vitamin K. This information was obtained from the website: https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=d91934a0-902e-c26c-23ca-d5accc4151b6# and from the website: https://vsearch.nlm.nih.gov/vivisimo/cgi-bin/query-meta?v%3Aproject=medlineplus&v%3Asources=medlineplus-bundle&query=vitamin+k&_ga=2.117115013.2081124811.1565615930-1667741437.1550160688 2. The facility staff failed to ensure all physician prescribed medications for Resident #93 were available for administration on 4/2/19, 4/3/19 and 4/4/19.	F755		

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F755	Continued From page 293 were not limited to heart disease, high blood pressure and major depressive disorder. Resident #93's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 6/28/19, coded the resident's cognition as severely impaired. Review of Resident #93's clinical record revealed the following physician's orders: -9/21/17- Flovent (1) 110 micrograms- two puffs, inhale orally two times a day. -3/23/19- Miacalcin (2) Solution 200 units- one spray alternating nostrils one time a day. Review of Resident #93's April 2019 MAR (medication administration record) revealed the above medications were held on the following dates: -Flovent was held on 4/2/19 at 9:00 a.m., 4/3/19 at 9:00 a.m. and 4/4/19 at 9:00 a.m. (nurses notes for all three dates documented the medication was pending and the nurse would administer when available). -Miacalcin was held on 4/2/19 at 9:00 a.m. and 4/3/19 at 9:00 a.m. (nurses notes for both dates documented the medication was pending and the nurse would administer when available). Resident #93's comprehensive care plan dated 2/27/19 documented, "(Name of Resident #93) is at risk for respiratory complications R/T (related to): having allergies Rhinitis (3)...Medications as ordered by the Physician..." The nurse responsible for administering Flovent and Miacalcin when the medications were held on 4/2/19, 4/3/19 and/or 4/4/19 was no longer employed at the facility. On 8/2/19 at 12:24 p.m., an interview was conducted with LPN (licensed practical nurse)	F755		

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F755	Continued From page 294 #7. LPN #7 was asked how nurses ensure medications are available for administration. LPN #7 stated, "We should call the pharmacy to see how long it's going to be and if past the allotted time for them to have it, we would notify the doctor." LPN #7 stated this should be documented in a nurse's note. LPN #7 was asked if there was a process to obtain the medications from the pharmacy. LPN #7 stated the Omni cell (an electronic machine containing various medications) should be checked and if the medications are not in there, nurses could call the pharmacy and ask them to send the medications STAT (immediately) but that could take anywhere from an hour to four hours. Review of the Omni cell list revealed Flovent and Miacalcin were not available in the Omni cell. On 8/6/19 at 11:25 a.m., ASM (administrative staff member) #1 (the administrator), ASM #2 (the regional clinical coordinator) and ASM #3 (the director of nursing) were made aware of the above concern. The facility/pharmacy policy titled, "7.0 Medication Shortages/Unavailable Medications" documented, "Procedure: 1. Upon discovery that Facility has an inadequate supply of a medication to administer to a resident, Facility staff should immediately initiate action to obtain the medication from Pharmacy. If the medication shortage is discovered at the time of medication administration, Facility staff should immediately take the action specified in Sections 2 or 3 of this Policy 7.0, as applicable. 2. If a medication shortage is discovered during normal Pharmacy hours: 2.1 Facility nurse should call Pharmacy to determine the status of the order. If the medication has not been ordered, the	F755		

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THE LAURELS OF UNIVERSITY PARK	2420 PEMBERTON RD RICHMOND, VA 23233

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F755	Continued From page 295 licensed Facility nurse should place the order or reorder for the next scheduled delivery. 2.2 If the next available delivery causes delay or a missed dose in the resident's medication schedule, Facility nurse should obtain the medication from the Emergency Medication Supply to administer the dose. 2.3 If the medication is not available in the Emergency Medication Supply, Facility staff should notify Pharmacy and arrange for an emergency delivery..." No further information was presented prior to exit. (1) Flovent is used to prevent difficulty breathing and wheezing. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a601056.html (2) Miacalcin is used to treat osteoporosis (a bone disease). This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a601031.html (3) "Allergic rhinitis is a diagnosis associated with a group of symptoms affecting the nose. These symptoms occur when you breathe in something you are allergic to, such as dust, animal dander, or pollen. Symptoms can also occur when you eat a food that you are allergic to." This information was obtained from the website:	F755		
F757 SS=K	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) 483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is	F757	F757 Resident #338: The resident no longer resides in the facility.	9/20/19

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F757	Continued From page 296 any drug when used- 483.45(d)(1) In excessive dose (including duplicate drug therapy); or 483.45(d)(2) For excessive duration; or 483.45(d)(3) Without adequate monitoring; or 483.45(d)(4) Without adequate indications for its use; or 483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or 483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review, clinical record review, review of facility documentation, and in the course of a complaint investigation the facility staff failed to ensure eight of nine residents, reviewed for anticoagulant (blood thinning) medication, (Residents #338, #116, #527, #45, #189, #129 #601 and #8), out of 72 sampled residents, received care and services, to ensure drug regimens free from unnecessary medications, and adequate monitoring for adverse outcomes, and safe administration, of the high-risk medication, Coumadin, resulting in harm to Resident #338. Resident #338. Resident #338 received no laboratory monitoring for the use of the high-risk anticoagulant (blood thinning medication)	F757	Resident # 116: The resident no longer resides in the facility. Resident #527: The resident no longer resides in the facility. Resident #45: No negative outcome occurred as a result of this practice. A stat PT/INR was ordered and a revised Coumadin log was initiated for the resident corresponding physician orders were transcribed into the EMR. Resident #189: No negative outcome occurred as a result of this practice. A stat PT/INR was ordered and a revised Coumadin log was initiated for the resident corresponding physician orders were transcribed into the EMR. Resident #129: The resident no longer resides in the facility. Resident #601: The resident no longer resides in the facility. Resident #8: No negative outcome occurred as a result of this practice. A stat PT/INR was ordered and a revised Coumadin log was initiated for the resident corresponding physician orders were transcribed into the EMR. Resident #96: No negative outcome occurred as a result of this practice. Non pharmacological interventions are being documented prior to PRN pain medication administration. Resident #27: No negative outcome occurred as a result of this practice. Non	

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F757	Continued From page 297 medication Coumadin [1], subsequently presented with bleeding, and was transferred to the hospital, where she received blood clotting medication and a blood transfusion, for gastrointestinal bleeding, resulting in harm. Review of current residents receiving Coumadin, identified the following concerns evidencing an ineffective system of monitoring for the safe administration of anticoagulant medications for seven out of eight current residents reviewed (Residents #116, #527, #45, #189, #129, #601, and #8): Staff failed to complete PT/INR monitoring per the physician/nurse practitioner's directive and/or order to ensure adequate monitoring and safe administration of Coumadin for seven current Residents (#116, #527, #45, #189, #129, #601, and #8), Staff failed to establish INR parameters (therapeutic goal) to monitor and ensure appropriate and safe administration of Coumadin for five current Residents (# 116, #527, #45, #129 and #601), Staff administered Coumadin doses instead of holding them per the physician/nurse practitioner's directive and/or order for three current Residents (#8, 189, and 129), Staff held Coumadin without a physician/nurse practitioner's directive or order for Resident #89 Staff failed to transcribe physician directives for Coumadin dose changes to the electronic medical record (EMR) and subsequently administered the wrong dose of Coumadin per the physician/nurse practitioner's directive for five current Residents (#527, #45, #189 #129 and #8), Staff failed to complete quality control/lot testing to ensure the accuracy of PT (prothrombin) INR (international normalized ratio) laboratory test, results for two current Residents (#8 and #189),	F757	pharmacological interventions are being documented prior to PRN pain medication administration. Resident #1: No negative outcome occurred as a result of this practice. Non pharmacological interventions are being documented prior to PRN pain medication administration. Resident #71: No negative outcome occurred as a result of this practice. Non pharmacological interventions are being documented prior to PRN pain medication administration. Residents receiving Coumadin and PRN pain medication have the potential to be affected. The Anticoagulation Therapy Record and policy have been updated, the Anticoagulation therapy process has been updated, the PT/INR competency checklist has been updated. The DON or designee has educated licensed nursing staff on the updated policies and procedures regarding Coumadin and education has been provided on implementing and documenting non pharmacological approaches for pain management. DON or designee has conducted an audit of current residents receiving Coumadin to ensure the new anticoagulation process has been followed. Competencies on licensed nursing staff were conducted for proper use of the coagucheck xs machine.	

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F757	Continued From page 298 Staff also failed to transcribe the provider's unsigned directives for PT/INR laboratory tests from the Anticoagulant Record, (maintained separately from the clinical record) into physician orders in the clinical record for six current Residents #116, #527, #45, #189, #601, and #8. In addition the facility staff failed to implement and monitor the effectiveness of non-pharmacological interventions per the physician's orders and plan of care prior to administering as needed (prn) pain medications to four of 72 sampled residents, (Resident #27, #96 #1, and #71). This failure resulted in Immediate Jeopardy and Substandard Quality of Care. The State Agency informed the facility on 8/1/19 at 3:45 p.m. of the Immediate Jeopardy situation. On 8/5/19 at 5:53 p.m., the Immediate Jeopardy was abated and lowered to a level III Isolated. The findings include: 1. Resident #338 received no laboratory monitoring for the use of the high-risk anticoagulant (blood thinning medication) medication Coumadin [1] from 6/29/18 through 7/23/18, presented with bleeding on 7/22/18, at 11: 46 p.m., which was not immediately addresses with the physician. On the morning of 7/23/18, the nurse practitioner evaluated Resident #338, and transferred her to the hospital, where she received blood clotting medication and a blood transfusion resulting in harm. Resident #338 was admitted to the facility on 6/29/18. Resident #338's diagnoses included	F757	An audit was done on Coagucheck xs machines to assure proper function. Residents receiving PRN pain medications will be audited for non-pharmacological approaches attempted prior to medication administration. DON or designee will continue to monitor Anticoagulant therapy logs and corresponding orders and EMR transcription, and documentation of non-pharmacological approaches will be monitored in the clinical meeting 5 days a week for 1 week, 3 days a week for 2 weeks, weekly for 4 weeks, and monthly for 3 months. Any variances will be corrected and additional education or counseling will be provided as needed Any concerns will be reported to the quality assurance committee monthly until resolved. Continued compliance will be monitored through the facility's quality assurance program. Additional education and monitoring will be initiated for any identified concerns. Completion Date: September 20, 2019	

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F757	Continued From page 299 but were not limited to revision of left total knee removal, asthma and high blood pressure. Resident #338's most recent MDS (minimum data set) (prior to discharge), a 14 day Medicare assessment with an ARD (assessment reference date) of 7/13/18, coded the resident as being cognitively intact. Section N coded Resident #338 as having received an anticoagulant medication seven out of the last seven days. Review of Resident #338's hospital record prior to discharge to the facility revealed Coumadin was initiated during the resident's hospitalization for dvt (deep vein thrombosis [2]) prophylaxis. Further review of the hospital record revealed a PT/INR (prothrombin time/international normalized ratio [3]) of 24.1/2.4 on 6/29/18. A hospital pharmacist note dated 6/29/18 documented, "Warfarin (Coumadin) dosing- Day #5 Consult provided for this 77 y.o. (year old) female to manage warfarin for VTE (sic) [DVT] prophylaxis s/p (status post) orthopedic surgery. INR Goal: 1.7-2.2. Drugs that may increase INR: Ceftriaxone [6]. Drugs that may decrease INR: None. Other current anticoagulants/drugs that may increase bleeding risk: NSAIDs (nonsteroidal anti-inflammatory drugs) [7]. Risk factors: > (greater than) 65. Daily INR ordered: Yes... Date INR Dose 6/15 1.0 6/25 4mg (milligrams) 6/26 1.0 mg 6/27 2.8 HOLD 6/28 2.1 2 mg 6/29 2.4 Hold Assessment/Plan: Will hold warfarin today for INR above goal. Pharmacy will continue to monitor daily and adjust therapy as indicated."	F757		

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F757	Continued From page 300 Review of Resident #338's clinical record revealed discharge orders from the hospital which were documented as being verified on 6/29/18 by a facility nurse with the on-call physician for ASM (administrative staff member) #5 (Resident #338's facility physician), documented an order for warfarin (Coumadin) 2 mg- one tablet by mouth daily for dvt (deep vein thrombosis) prevention. Further review of the discharge orders verified by the facility on-call physician failed to reveal any orders for a PT/INR or any orders for the monitoring of adverse outcomes. Warfarin (Coumadin) is in a class of medications called anticoagulants ('blood thinners'). It works by decreasing the clotting ability of the blood. [1] Black Box Warning [A boxed warning is the strongest warning that the FDA (Food and Drug Administration) requires, and signifies that medical studies indicate that the drug carries significant serious or even life-threatening adverse effects]: BLEEDING RISK: COUMADIN can cause major or fatal bleeding. Perform regular monitoring of INR [international normalized ratio - a laboratory blood test that measures how long it takes for blood to clot [3]] in all treated patients. [4] Warfarin therapy may be prescribed for patients with certain types of irregular heartbeat, blood clots in the legs or lungs, and patients who have certain medical device implants such as artificial heart valves. Warfarin must be monitored to ensure it is working effectively and being used safely. Achieving the correct warfarin dosage can be difficult but is extremely important. If the dose of warfarin is too low, the patient is at risk of developing harmful blood clots. If the dose of	F757		

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F757	Continued From page 301 warfarin is too high, the patient may be at risk of serious bleeding. A health care provider sets an INR [International normal ratio] target range. It is typically between 2.0 and 3.0 for basic blood-thinning needs, though the range may vary based on a patient's specific conditions. An INR above the patient-specific target range may increase the risk of bleeding, while an INR below the target range may increase the risk of developing a blood clot. [5] Review of Resident #338's clinical record revealed a physician's order dated 6/29/18, the date of admission to the facility that documented an order for Coumadin- 2 mg by mouth in the evening for DVT prophylaxis. Review of Resident #338's June 2018 and July 2018 MARs (medication administration records) revealed the resident was administered 2 mg of Coumadin as prescribed by the physician from 7/1/18 through 7/22/18. [This review also revealed there were no orders for PT/INR laboratory testing for the administration of Coumadin to Resident #338]. Resident #338's baseline care plan (no date) documented "Anticoagulant- (a check mark beside) Observe S/S (signs or symptoms) of bleeding, report as indicated..." Resident #338's comprehensive care plan dated 7/11/18 documented, " BLEED101: At risk for abnormal bleeding R/T (related to) anticoagulant use...Interventions: Administer medications as ordered...Observe for abnormal s/sx (signs/symptoms) of bleeding. i.e. Bruising, bleeding gums, petechiae (tiny red spots caused by bleeding into the skin), nosebleeds, hematuria (bloody urine), headaches, back of abdominal pain, decrease blood pressure or pulse, occult blood in the stool, etc. Obtain labs [laboratory tests] as ordered. Report abnormal findings to physician. Report all abnormal	F757		

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F757	Continued From page 302 findings to physician..." Further review of Resident #338's clinical record (including nurses' notes, NP [nurse practitioner] notes and physician notes from date of admission on 6/29/18 to date of discharge to the hospital on 7/23/18) failed to reveal any documentation of monitoring for the prescribed use of Coumadin. The physician note dated 7/2/18 failed to document information regarding Coumadin or monitoring for the medication. The NP notes dated 7/3/18, 7/10/18, 7/11/18, 7/12/18, 7/16/18, 7/17/18, 7/18/18, 7/19/18 and 7/20/18 documented information regarding, "Pertinent lab results" but failed to document any information regarding PT/INRs and Coumadin monitoring. The notes further documented, "On Coumadin therapy for DVT prophylaxis..." but failed to document any information regarding the monitoring of Coumadin. There was no anticoagulant record for Resident #338. (The "Anticoagulant Record" a tracking flowsheet that was being utilized by facility staff for Coumadin monitoring separate from the clinical record. It includes the date, current anticoagulant drug and dose, PT/INR, name of the nurse who completed the PT/INR, the test strip lot number, quality control test for the machine used to test for the PT/INR, the date the physician was notified and action taken by the physician. Directives for testing and Coumadin dose changes were documented on the sheet by nurses and physicians but were not signed and the facility did not have a policy regarding the process and use of the flowsheet). Review of notes documented by the pharmacist on 7/2/18 and 7/21/18 revealed the pharmacist reviewed Resident #338's clinical record on those dates. The notes failed to document any information regarding the use of Coumadin or	F757		

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F757	Continued From page 303 monitoring for the medication. Review of Resident #338's June 2018 and July 2018 MARs (medication administration records) revealed the resident was administered 2 mg of Coumadin as prescribed by the physician from 7/1/18 through 7/22/18 (including on 7:22 at 5:00 p.m.) A nurse's note dated 7/22/18 at 11:46 p.m. documented, "It was reported that guest has blood stain on bed linen. Bright red blood observed on linen unable to determine if vaginal bleed. Trace bright red blood on washcloth after pericare. Guest has + (positive) bowel sounds which are hyperactive in all 4 quadrants." A NP (nurse practitioner) note dated 7/23/18 at 8:30 a.m. documented, "CC (Chief Complaint): blood in stool. HPI (History of Present Illness): ATSP (Asked to See Patient) for blood in stool. Patient reports bright red blood per rectum on several occasions over the weekend. States that she has had blood on her pad and bed. Endorses abdominal pain and burning, diarrhea, and nausea. Unsure if there was blood in the toilet with BM (bowel movement) this morning, was unable to see. Has tried Zofran [7] and pain medication over the weekend with no relief...A/P (Assessment/Plan) GI (gastrointestinal) bleeding: referred to ER (emergency room)..." Resident #338 was transferred to the hospital on 7/23/18 for bleeding. Review of hospital records revealed Resident #338's INR* was 11.8 on 7/23/18. The resident was administered Vitamin K [9] and underwent a blood transfusion on 7/24/18. *"Prothrombin time (PT) is a blood test that measures the time it takes for the liquid portion	F757		

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F757	Continued From page 304 (plasma) of your blood to clot." "PT is measured in seconds. Most of the time, results are given as what is called INR (international normalized ratio)." "The most common reason to perform this test is to monitor your levels when you are taking a blood-thinning medicine called warfarin [Coumadin]. You are likely taking this medicine to prevent blood clots. Normal Results: PT is measured in seconds. Most of the time, results are given as what is called INR (international normalized ratio). If you are taking warfarin to prevent blood clots, your provider will most likely, choose to keep your INR between 2.0 and 3.0." [3] On 7/31/19 at 2:36 p.m., an interview was conducted with ASM (administrative staff member) #5 (Resident #338's physician at the facility). ASM #5 was asked about the process for Coumadin monitoring for a resident newly admitted to the facility. ASM #5 stated the process depends on the orders provided by the hospital. ASM #5 stated the hospital usually specifies the next date a PT/INR should be obtained and that order should be followed. ASM #5 was asked what should be done if the hospital does not provide an order for a PT/INR. ASM #5 stated usually she would review the resident's chart, find out the last date a PT/INR was checked and order for a PT/INR to be checked within the next few days. ASM #5 stated she likes to have a baseline PT/INR and the value of that PT/INR will determine when the next one should be done. ASM #5 stated the facility staff obtains PT/INRs and documents them in the "Coumadin book" (anticoagulant record). ASM #5 stated the clinician can be proactive and check the anticoagulant record or often, the nurses will flag the anticoagulant record for a recently obtained PT/INR or the nurses will verbally tell her that they checked a	F757		

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F757	Continued From page 305 resident's PT/INR and ask for her review. ASM #5 was asked why Coumadin must be monitored. ASM #5 stated Coumadin (levels) could quickly become out of control because the medication can variably react with food and other medications. ASM #5 stated this is why the medication has to be monitored. ASM #5 was asked how often PT/INRs should be obtained to monitor Coumadin. ASM #5 stated that depends on the patient and other variables. When asked where staff document the monitoring of Coumadin and PT/INR tests, ASM #5 stated it (PT/INR laboratory tests) is documented in the Coumadin book (anticoagulant record). When asked how orders for Coumadin changes and PT/INRs are communicated, ASM #5 stated those are written in the anticoagulant record. She stated she does not write actual orders for those. When asked who is responsible for overseeing the anticoagulant record, ASM #5 stated she was not sure but she assumed the unit managers. ASM #5 was made aware there was no evidence of Coumadin monitoring in Resident #338's clinical record and no evidence of an "Anticoagulant Record" for the resident. ASM #5 reviewed her notes and stated she had no documentation in her notes. On 7/31/19 at 2:45 p.m. and 4:57 p.m., ASM #1 (the administrator) was asked to provide Resident #338's anticoagulant record. On 8/1/19 at 7:57 a.m., ASM #1 stated she could not find Resident #338's anticoagulant record. On 8/1/19 at 8:46 a.m., an interview was conducted with RN (registered nurse) #1, regarding the facility process for Coumadin monitoring. RN #1 stated when a resident is admitted, she tells the doctor the resident is	F757		

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F757	Continued From page 306 receiving Coumadin and asks the doctor if she should obtain a PT/INR so there is a baseline before the first dose of Coumadin is given. RN #1 stated she enters the Coumadin order into the computer system, obtains a PT/INR and immediately notifies the doctor. RN #1 stated she makes the doctor aware of the PT/INR results and asks if he/she wants to continue the prescribed dose of Coumadin, make changes, and when the next PT/INR should be done. RN #1 stated she obtains this information then documents the current Coumadin dose, the PT/INR results and action taken by the physician, including the due date for the next PT/INR on the anticoagulant record. When asked if actual physician's orders are written, RN #1 stated she would put an order into the computer for a Coumadin dose change but she thought orders for PT/INRs are not written and are only documented in the anticoagulant record. On 8/1/19 at approximately 10:45 a.m., ASM #1 was asked to provide the anticoagulant policies. On 8/1/19 at 1:36 p.m., a telephone interview was conducted with ASM #8 (the consulting pharmacist), regarding the pharmacy process for Coumadin monitoring. ASM #8 stated he typically reviews the medications prescribed for a newly admitted resident within three days of admission and then monthly. ASM #8 was asked if he identifies whether a PT/INR has been obtained for residents receiving Coumadin. ASM #8 stated usually residents are admitted from the hospital with a PT/INR order and sometimes he completes his medication review before the facility physician evaluates the resident. ASM #8 was asked if he noticed that a PT/INR had not been obtained for Resident #338 during her stay at the facility. ASM #8	F757		

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F757	Continued From page 307 stated the resident's INR was stable at the hospital on 6/28/18 so he would have reviewed for the need for a PT/INR during his monthly review. ASM #8 stated a PT/INR would not have been due until 7/24/18. When asked why, ASM #8 stated monthly monitoring of PT/INRs was a common clinical practice. ASM #8 was asked to provide and fax the reference for the common clinical practice to this surveyor. On 8/1/19 at 2:25 p.m., ASM #1 (the administrator) provided a fax from ASM #8. The fax documented, "Comments: See below verbiage for warfarin/anticoagulant monitoring references: Please ensure that the INR was obtained, communicating the result to the prescriber and documenting in the medical record as soon as it becomes available. Rationale for Recommendation; Continuous appropriate INR and clinical monitoring of warfarin therapy is required to avoid preventable events (e.g. embolism [blood clot], bruising, bleeding). References: 1) Coumadin prescribing information. Princeton, NJ: Bristol-Myers Squibb Company. 2017 Aug. 2) Gurwitz JH et al. The safety of warfarin therapy in the nursing home setting. The Am J Med. 2007; 120:539-544." On 8/1/19 at approximately at approximately 2 p.m. ASM #1, the administrator provided the policy titled Anticoagulant Therapy. The facility policy titled, "ANTICOAGULANT THERAPY" (revised 10/10), documented, "Policy: Anticoagulant therapy delays clotting and prevents formation of a thrombus (blood clot) in immobile and/or postoperative guests, as well as intercepting the extension of a thrombus once it has formed. Periodic prothrombin time tests are done to control the administration of anticoagulants. Procedure:	F757		

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F757	Continued From page 308 1. Verify physician's order. 2. Explain the procedure to the guest. 3. Obtain the blood specimen prior to the guest's daily dose of Coumadin. 4. Collect approximately 5 to 7 ml (milliliters) of venous blood in a blue top tube. 5. List on the laboratory slip any drugs that may affect test results. 6. After obtaining the specimen, apply pressure to the venipuncture site. 7. If the PT is greatly prolonged, evaluate the guest for bleeding tendencies (blood in the urine and all excretions, bruises, petechiae [tiny red dots on the skin resulting from broken blood vessels bleeding into the skin] and low back pain). 8. A licensed nurse will notify the physician of the test results. 9. The physician will re-order the drug, the dosage to be given, and the date the Prothrombin time is to be repeated. 10. All scheduled Prothrombin times will be placed in the lab book..." The policy failed to document any information regarding the anticoagulant records. The facility was not aware of or using a policy for the "Anticoagulant Record" which was maintained separately from the clinical record until it was full. After determining harm existed for Resident #338, due to inadequate monitoring for the administration of Coumadin, eight of the current residents receiving Coumadin were added to the survey sample, and the clinical records were reviewed. The survey team identified concerns for seven of the eight current residents reviewed, which revealed the facility an ineffective process for monitoring and the safe administration of anticoagulant therapy. The following concerns were identified:	F757		

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F757	Continued From page 309 - Staff failed to establish INR parameters (therapeutic range and goal) for monitoring and the safe administration of Coumadin, (Resident # 116, #527, #45, #129 and #601), - PT/INR monitoring, was not obtained per physician/nurse practitioner's directive and/or order to ensure adequate monitoring and the safe administration of Coumadin for seven of the eight current residents (Residents #116, #527, #45, #189, #129, #601, and #8), -Coumadin was administered, and not held per physician/nurse practitioner's directive and/or order, (Resident #189 and #8), - Coumadin was not, administered per physician/nurse practitioner's directive and/or order resulting in administration of the wrong dose of Coumadin, (Resident #527, #45, #129, #189, #8), - Quality control/lot, testing was not completed. Staff failed to ensure the code on the strips matched coagu-chek machines, to ensure accuracy of the coagu-chek machines/ PT INR, results, (Resident #189 and #8). -Staff failed to transcribe PT/INR laboratory-test directives from the anticoagulant record to physician's orders in the electronic medical record, (#116, #527, #45, #189, #601, and #8). The findings of Immediate Jeopardy and substandard quality of care were confirmed with three supervisors, on 8/1/19 at approximately 3:15 p.m., during a phone call with the State Agency. On 8/1/19 at 3:45 p.m., ASM #1 (the administrator), ASM #2 (the regional clinical coordinator) and ASM #3 (the director of nursing) were made aware of the above findings for IJ (Immediate Jeopardy) and substandard Quality of Care situation.	F757		

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F757	Continued From page 310 On 8/2/19 at 12:55 p.m., another telephone interview was conducted with ASM #8 (the consulting pharmacist). ASM #8 was made aware of the completed a medication review for Resident #338 on 7/21/18 and was asked why he did not complete a review of the resident's Coumadin monitoring. ASM #8 stated the computer software notifies him regarding a needed review one month after the last INR entered into the software. ASM #8 stated if the last INR was obtained in the hospital and he entered that INR into the software, then the software would not flag for him to complete a review for an INR need until one month after the resident is admitted to the facility. ASM #8 stated he completes the review after the computer software flags for him to do so. Review of notes documented by ASM #8 on 7/2/18 and 7/21/18 revealed ASM #8 reviewed Resident #338's clinical record on those dates. The notes failed to document any information regarding the use of Coumadin or monitoring for the medication. 8/2/19 at 3:20 p.m., during a telephone call by the team coordinator with ASM #1, the administrator and ASM #2, (the regional clinical coordinator) regarding an acceptable POC (plan of correction) and abatement of the IJ (immediate jeopardy), ASM #2 the stated that they had located a policy on the "Anticoagulation Record." When asked if the policy addressed the process, ASM #2 stated it does not address the whole of the process. ASM #1 and ASM #2 were asked to present a new POC that addressed the process on 8/5/19. This call ended on 8/2/19 at 3:30 p.m. On 8/5/19 at 12:18 p.m., the facility staff provided a POC (plan of correction), which, was	F757		

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F757	Continued From page 311 reviewed by the survey team. The POC documented, "(Name of facility) submits the following Credible Allegation of Compliance outlining the measures it has completed to abate the findings of immediate jeopardy to resident health and safety identified by the surveyor regarding the facility's alleged failure to monitor for adverse reactions or drug effectiveness in conjunction with residents receiving Coumadin/Warfarin. (Name of facility) believes that as of 8-5-19, the measures it has implemented are sufficient to demonstrate that our residents are not at risk for failure to monitor for adverse reactions or drug effectiveness in conjunction with residents receiving Coumadin/Warfarin. Resident #338 no longer resides at the facility. Resident #601 has had no negative outcomes as a result of this alleged deficient practice, a stat PT/INR was obtained. Resident #527 has had no negative outcomes as a result of this alleged deficient practice, a stat PT/INR was obtained. Resident #8 has had no negative outcomes as a result of this alleged deficient practice, a stat PT/INR was obtained. Resident #189 has had no negative outcomes as a result of this alleged deficient practice, a stat PT/INR was obtained. All residents on Coumadin therapy have the potential to be affected. Unit Manager obtained stat PT/INR orders from Medical Director PT/INR was obtained on all residents receiving Coumadin. Results were given to the Medical Director and he gave telephone orders for when to re-check the PT/INR and Coumadin dosage changes where applicable. All orders were transcribed into the EMR (electronic medical record). [*Note the facility through previous unacceptable POC indicated this was completed the evening of	F757		

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F757	Continued From page 312 8/1/19]. ADON (Assistant Director of Nursing) conducted a skin assessment on all residents receiving Coumadin to identify abnormal bruising or bleeding. There were no abnormal findings. Therapeutic ranges have been obtained, transcribed and care planned. Unit Manger checked all CoaguChek XS machines for quality controls and to ensure test strips and machine chips match to ensure proper functioning per manufacturer guidelines. Unit manager obtained telephone orders for residents receiving Coumadin to monitor for adverse reactions (abnormal bruising and/or bleeding) and to report abnormal findings to the MD (medical doctor). All orders were transcribed into the EMR. DON (Director Of Nursing) initiated clean, new copies of the anticoagulant record for each guest on Coumadin that indicates therapeutic. They are in a Coumadin tracking book on each nursing unit. An anticoagulant therapy process has been created. The PT/INR: Anticoagulant record policy has been updated to reflect transcription in the EMR. The DON or designee, will educate licensed nursing staff on the new anticoagulant therapy process. Coaguchek XS competencies will be conducted on licensed nursing staff and licensed nurses that have not received competencies, will not be allowed to obtain PT/INR from residents. Licensed nursing staff will be educated on the Anticoagulant therapy process during nursing orientation. The DON or designee will educate nursing administration on the routine monitoring of the anticoagulant log during clinical meetings to ensure accuracy, completion, and that appropriate orders are in place. Nursing administration will monitor anticoagulant	F757		

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F757	Continued From page 313 logs ongoing in the clinical operations meeting. This is a process change that will continue indefinitely. The DON and NHA will report all findings to the QA committee. Date of compliance 8/5/19 Attachments: Anticoagulation therapy process PT/INR - Anticoagulation record policy PT/INR: Using the coaguchek xs system Coaguchek XS system competency Skills Checklist. Anticoagulant Therapy Process - Effective 8/5/19 Effective monitor guests/residents receiving anticoagulant therapy and reduce the risk of bleeding. INFORMATION Anticoagulant therapy is utilized as a prophylaxis and treatment of venous thrombosis, pulmonary embolism, thrombotic disorders, Atrial - Fibrillation with embolism and prophylaxis of systemic embolism after Myocardium Infarction. They inhibit the development of a thrombus. PROCEDURE If using Coumadin for Anticoagulant therapy. Initiate and order PT/INR test in EMR per physician's order, confirm desired PT/INR testing schedule and PT/INR therapeutic range at the time of testing. Initiate anticoagulant record and follow PT/INR. Anticoagulant record policy. Anticoagulant records will be maintained in a Coumadin tracking book on each nursing unit. Follow the Policy PT/INR: Using the coaguchek xs system to obtain PT/INR. Document tests results on the anticoagulant record using the PT/INR. Anti-coagulant record Policy. Transcribe all physician orders from the	F757		

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F757	Continued From page 314 anticoagulant record into the EMR. Monitor resident every shift for adverse reactions including abnormal bleeding and/or bruising. Document that monitoring occurred on the MAR. Report abnormal Findings (including PT/INR outside of the therapeutic range or abnormal bleeding and/or bruising) to the MD and document findings and notification in EMR. Nurses who perform PT/INR tests must have a Coaguckek XS competency completed upon hire prior to obtaining PT/INR on residents and yearly thereafter and as needed. Anticoagulant logs will be reviewed by nursing administration in the clinical operations meeting to ensure completion and accuracy. DOCUMENTATION 1. Physician order 2. Progress Notes 3. Anticoagulant record 4. Medication administration Record 5. Guest/resident Care Plan." On 8/5/19 at 2:26 p.m., the POC was accepted. Verification of the education, on the new anticoagulant process presented in the POC was conducted. The education documents were reviewed, including the new anticoagulant process. Review of all staff competencies, and verification was completed. Observation of proper use of the CoaguChek machines was conducted and confirmed. Staff were interviewed on each shift, (7-3, 3-11 and 11-7) to verify the education provided and all staff responses were appropriate. All medical records were reviewed and the MD (medical doctor) orders obtained for the POC were verified including any changes for Coumadin doses or changes in PT/INRs. All newly initiated "clean" "Anticoagulant Records" were reviewed and crossed check for transcription of orders,	F757		

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F757	Continued From page 315 Coumadin doses, laboratory testing, and therapeutic goals. Verification of the CLIA (Clinical Laboratory Improvement Amendments) certificate was completed. Review of the manufacturer's user manual for the CoaguChek machines and proper procedures was completed and observations for proper procedures by staff conducted. On 8/5/19 at 2:30 p.m., an interview was conducted with ASM #1, ASM #2 and ASM #3. When asked if they were aware of the situation that was uncovered (regarding the ineffective process for the safe administration of Coumadin and monitoring), ASM #3 stated, "No. The nurses were not necessarily doing the process and they assumed the doctor was putting the orders in the system and the doctors assumed the nurses were putting the order in the EMR (electronic medical record)." On 8/5/19 at 3:44 p.m., an interview was conducted with RN (registered nurse) #8. RN #8 was asked if physician's orders regarding Coumadin and PT/INRs should be written. RN #8 stated physician's orders to hold Coumadin, change a dose of Coumadin, and for the next PT/INR that is due should be written. When asked the facility process for ensuring the orders are written, RN #8 stated the anticoagulant records should be reviewed each morning. On 8/5/19 at 5:53 p.m., after verification of the POC was completed, the IJ was abated. On 8/6/19 at 7:53 a.m., an interview was conducted with ASM #7 (the nurse practitioner). ASM #7 was asked to describe her role and responsibility regarding Coumadin monitoring. ASM #7 stated residents typically are admitted from the hospital with an order that determines	F757		

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F757	Continued From page 316 when the PT/INR should be re-checked. ASM #7 stated if she is reviewing a resident's orders then she usually asks the nurses to check the resident's PT/INR on the day of admission then determines if any changes to the Coumadin needs to be made and when to check the next PT/INR based on the PT/INR obtained that day. ASM #7 stated sometimes when a resident is admitted from the hospital, the clinicians are trying to establish a therapeutic Coumadin range. ASM #7 stated the therapeutic range is based on the resident's diagnosis and sometimes residents are admitted from the hospital with a documented therapeutic range but if not, she determines the desired therapeutic range based on the resident's diagnoses. ASM #7 stated there is a "Coumadin book" (containing anticoagulant records) on each unit in the facility, and the books are checked each day Monday through Friday. ASM #7 stated she and the physician rotate units they visit in the facility. ASM #7 stated each day, she visits a unit, and she checks the Coumadin book. ASM #7 stated anticoagulant records, are organized in the Coumadin book based on the day of the week, so if she visits on a Tuesday, she checks the tabbed section of anticoagulant records for Tuesday. ASM #7 stated she reviews the anticoagulant records in that day's tabbed section and reviews if the INR is done, or asks, for the INR to be completed. ASM #7, was asked what happens if changes need to be made based on the current INR. ASM #7 stated she writes the directive for the needed changes in the "Action Taken By Physician" column on the anticoagulant record, and then the nurse is supposed to check the record and write the orders for the needed changes. ASM #7 stated at times, she gives verbal directives then the nurses document the	F757		

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F757	Continued From page 317 directives on the anticoagulant record. ASM #7 was asked if the directives written in the "Action Taken By Physician" column on the anticoagulant records have the full weight of a physician's order. ASM #7 stated, "Yes." ASM #7 was asked if nurses are expected to take the information documented in the "Action Taken By Physician" column and enter that information (transcribe) onto a physician's order written into the computer system. ASM #7 the nurses take that information and enter orders into the computer system for medication changes, but as far as how the orders are entered into the system, would be a question to ask the assistant director of nursing. ASM #7 was asked if she signs off on the directives the nurses write on the anticoagulant records. ASM #7 stated she does not sign the directives, but she thought most of the time, the nurses take the directives and enter them as orders into the computer system. ASM #7 stated if the directives are entered into the computer system, then they will be entered as orders under her name and the orders will display for her to sign. When ASM #7 was asked if nurses should follow the directives in the anticoagulant records, she stated, "Yes." When ASM #7 was asked if a change in Coumadin dose should be initiated the same day the directive is written, she stated, "Yes." ASM #7 was asked if directives for the next due PT/INR documented in the anticoagulant records should be followed. ASM #7 stated, 'Yes." ASM #7 stated she did not know if PT/INR directives documented on the anticoagulant records are entered into the computer system as actual orders, or if the nurses use the directives in the anticoagulant record as written orders. ASM #7 was asked if she could provide any	F757		

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F757	Continued From page 318 information regarding Resident #338's Coumadin monitoring. ASM #7 stated she began employment at the facility on 6/24/18. ASM #7 stated initially, the only place she documented monitoring information (such as Coumadin dose and PT/INRs) was on the anticoagulant records. ASM #7 stated that over time, she notices that the monitoring information was more clear to her and helped her follow her plan of care when she documented the information in her notes and she now does that. ASM #7 was asked to provide any further information regarding Resident #338's Coumadin monitoring, other than what was documented in her notes. ASM #7 was asked if Resident #338 or any staff reporting any bleeding episodes during the weekend prior to her examination of the resident on Monday 7/23/18. ASM #7 stated that information was not in her notes and she could not recall. On 8/6/19 at 9:39 a.m., a telephone interview was conducted with ASM #9 (the facility medical director), regarding the facility Coumadin monitoring process and his role as the medical director. ASM #9 stated in general, he attends the monthly facility QAPI (quality assurance and performance improvement) meetings and ad hoc meetings that are held for issues that need to be addressed. ASM #9 stated he also participates in the facility policy and procedure reviews. ASM #9 stated he does not currently have any patients who reside at the facility but providers from the company he is employed at do. ASM #9 stated Coumadin monitoring is a partnership between the nursing staff, the pharmacist, the doctors and the nurse practitioners. When ASM #9 was asked if he was aware of any concerns regarding Coumadin monitoring (prior to the survey), he stated he was not.	F757		

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	495109	A. BUILDING _____ B. WING _____	C 08/07/2019

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F757	Continued From page 319 ASM #9 was asked what monitoring is expected for a resident receiving Coumadin admitted to the facility. ASM #9 stated in general, the facility physicians are getting orders from the hospital and this is about transition of care. ASM #9 stated, if a resident is admitted from an acute care environment then the resident should have medication and PT/INR check orders that are submitted to the facility staff, and the interdisciplinary team reviews, follows and implements the orders and discharges the patient when appropriate. ASM #9 stated appropriate recommendations and order clarifications should be obtained for any medication that requires supervision. ASM #9 was asked if there was any special items (recommendations) for Coumadin. ASM #9 stated that it goes back to all medications, including the right drug and the right dose. ASM #9 was asked if the use of Coumadin requires any lab monitoring and stated INRs and the therapeutic index should be checked. When asked who is responsible for Coumadin monitoring, ASM #9 stated that while residents are admitted under the care of the attending physicians, residents often have outside providers such as a cardiologist. ASM #9 stated the attending physicians review the medications that residents were on in the hospital and decide what is needed to be done at the facility. ASM #9 stated there is a shared responsibility between the attending physicians and the outside providers because the physicians want optimal transition of care. ASM #9 was asked if he could provide information for the facility process regarding the anticoagulant records. ASM #9 stated he had a general understanding of that process for the facility company but he had not recently used the anticoagulant records in that particular facility and did not have any specific information.	F757		

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F757	Continued From page 320 The nurse who wrote the 7/22/18 note that documented a bloodstain was observed on Resident #338's sheet was no longer employed at the facility. On 8/6/19 at 11:23 a.m., an interview was conducted with ASM #3 (the director of nursing), regarding her role in Coumadin monitoring. ASM #3 stated the anticoagulant records, were supposed to be reviewed during daily clinical operations meetings but that had not been "getting" done so now the records will be reviewed daily at the meetings to ensure orders for PT/INRs and Coumadin are written, transcribed and done. On 8/6/19 at 12:04 p.m., another interview was conducted with ASM #9 (the facility medical director). ASM #9 was what staff should do if a resident on Coumadin is observed with a bright red bleeding. ASM #9 stated immediately called the supervisor and doctor. When asked why, ASM #9 stated, "It's a significant change in condition." No further information was presented prior to exit. COMPLAINT DEFICIENCY [1] "Warfarin (Coumadin) is used to prevent blood clots from forming or growing larger in your blood and blood vessels. It is prescribed for people with certain types of irregular heartbeat, people with prosthetic (replacement or mechanical) heart valves, and people who have suffered a heart attack. Warfarin is also used to treat or prevent venous thrombosis (swelling and blood clot in a vein) and pulmonary embolism (a	F757		

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F757	Continued From page 321 blood clot in the lung). Warfarin is in a class of medications called anticoagulants ('blood thinners'). It works by decreasing the clotting ability of the blood." This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a682277.html [2] "Deep vein thrombosis, or DVT, is a blood clot that forms in a vein deep in the body. Most deep vein clots occur in the lower leg or thigh. If the vein swells, the condition is called thrombophlebitis. A deep vein thrombosis can break loose and cause a serious problem in the lung, called a pulmonary embolism." This information was obtained from the website: https://vsearch.nlm.nih.gov/vivisimo/cgi-bin/query-meta?v%3Aproject=medlineplus&v%3Asources=medlineplus-bundle&query=dvt&_ga=2.137988019.2081124811.1565615930-1667741437.1550160688 [3] "Prothrombin time (PT) is a blood test that measures the time it takes for the liquid portion (plasma) of your blood to clot." "PT is measured in seconds. Most of the time, results are given as what is called INR (international normalized ratio)." "The most common reason to perform this test is to monitor your levels when you are taking a blood-thinning medicine called warfarin. You are likely taking this medicine to prevent blood clots. Normal Results: PT is measured in seconds. Most of the time, results are given as what is called INR (international normalized ratio). If you are taking warfarin to prevent blood clots, your provider will most likely, choose to keep your INR between 2.0 and 3.0." This information was obtained from the website: https://vsearch.nlm.nih.gov/vivisimo/cgi-	F757		

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F757	Continued From page 322 3asources=medlineplus-bundle&query=laboratory%20tests%20for%20PT%20calculation%20of%20INR& [4] Black Box Warning [A boxed warning is the strongest warning that the FDA (Food and Drug Administration) requires, and signifies that medical studies indicate that the drug carries significant serious or even life-threatening adverse effects]: BLEEDING RISK: COUMADIN can cause major or fatal bleeding. Perform regular monitoring of INR [international normalized ratio - a laboratory blood test that measures how long it takes for blood to clot [3]] in all treated patients. [3]This information was obtained from the webiste:https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=d91934a0-902e-c26c-23ca-d5accc4151b6 [6] Ceftriaxone is used to treat infections. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a685032.html [7] "NSAIDs (nonsteroidal anti-inflammatory drugs) are some of the most commonly used pain medicines in adults." This information was obtained from the website: https://www.rheumatology.org/I-Am-A/Patient-Caregiver/Treatments/NSAIDs [8] Zofran is used to prevent nausea. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a601209.html [9] "Vitamins are substances that your body needs to grow and develop normally. Vitamin K helps your body by making proteins for healthy bones and tissues. It also makes proteins for	F757		

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F757	Continued From page 323 K, you may bleed too much." Reversal of COUMADIN anticoagulation may be obtained by discontinuing COUMADIN therapy and, if necessary, by administration of oral or parenteral vitamin K. This information was obtained from the website: https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=d91934a0-902e-c26c-23ca-d5accc4151b6# and from the website: https://vsearch.nlm.nih.gov/vivisimo/cgi-bin/query-meta?v%3Aproject=medlineplus&v%3Asources=medlineplus-bundle&query=vitamin+k&_ga=2.117115013.2081124811.1565615930-1667741437.1550160688 2. The facility staff failed to ensure Resident #116, received adequate monitoring for the anticoagulant (blood thinning medication) medication Coumadin (1), to ensure appropriate administration of the high-risk medication. There were no identified therapeutic goals for the administration of Coumadin and the facility staff failed to obtain a PT/INR (prothrombin time/international nationalized ratio) (2), per physician/NP (nurse practitioner) directive on the anticoagulant record on 6/8/19 and 6/14/19. The staff also failed to transcribe the physician/NP directive for PT/INR monitoring from the anticoagulant record to Resident # 116's EHR (electronic health record) on 6/5/19 for 6/8/19. Resident #116 was admitted to the facility on 6/4/19. Resident #116's diagnoses included but were not limited to muscle weakness and chronic embolism (blood clot) and thrombosis (blood clot) of unspecified deep veins of left lower extremity. Resident #116's most recent MDS (minimum data set), a 30 day Medicare	F757		

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F757	Continued From page 324 being cognitively intact. Section N coded Resident #116 as having received an anticoagulant medication seven out of the last seven days. Resident #116's comprehensive care plan dated 6/14/19 documented, "(Name of Resident 116) is at risk for abnormal bleeding/bruising R/T (related to) Anticoagulant use...Administer medications as ordered. Observe for ineffectiveness and side effects, report abnormal findings to the physician. Obtain labs and diagnostics as ordered and report abnormal findings to the physician..." A review of the physician/NP progress notes from admission to the time of the survey revealed no evidence of an identified therapeutic goal (parameter) for Resident #116's PT/INR. Review of Resident #116's clinical record revealed a physician's order dated 6/5/19 for a PT/INR one time only. Review of Resident #116's anticoagulant record revealed documentation dated 6/5/19 that documented, "Current Anticoagulant Drug and Dose: last dose (Coumadin) 5 mg was held 6/2, 3 & 4. PT: 31.9. INR: 2.7. Action Taken By Physician: restart (Coumadin) 3.5 mg QD (every day) re (check) (PT/INR) 6/8/17 (sic)..." Further review of Resident #116's clinical record revealed a physician's order dated 6/5/19 for Coumadin 3.5 mg (milligrams) in the evening but failed to reveal a transcribed physician's order for a PT/INR on 6/8/19. A note signed by ASM (administrative staff member) #5 (Resident #116's physician) on 6/5/19 failed to document information regarding	F757		

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F757	Continued From page 325 Coumadin use or monitoring. A note signed by ASM #7 (nurse practitioner) on 6/6/19 failed to document information regarding Coumadin use or monitoring. On 6/8/19, the anticoagulant record documented, "Current Anticoagulant Drug and Dose: 3.5 mg QD. PT: (blank) INR: 1. Action Taken By Physician: (blank)." Further review of the anticoagulant record and physician's orders failed to reveal a physician/NP directive and/or order for the next PT/INR. (Note- as documented below, , an interview with LPN [licensed practical nurse] #1 on 8/6/19 at 10:54 a.m., revealed the 6/8/19 entry was documented in error and a PT/INR was not obtained on 6/8/19, as ordered). On 6/10/19, the anticoagulant record documented, "Current Anticoagulant Drug and Dose: 3.5 mg. PT: 21.9. INR: 1.8. Action Taken By Physician: (An arrow pointing up to indicate the word increase) 4 mg. Re (check) 6/14/19." A note signed by the ASM (administrative staff member) #7 on 6/10/19 documented in part, "H/o (History of) DVT (deep vein thrombosis) (3) - on coumadin 3.5mg (milligrams) QD (every day). INR today 1.8. Increase coumadin to 4mg QD and re check 6/14/19. Monitor closely..." Review of physician's orders failed to reveal a transcribed physician order to recheck Resident #116's PT/INR on 6/14/19. A note signed by ASM #7 on 6/11/19 and 6/12/19 documented in part, "H/o DVT- on coumadin 4mg QD. Most recent INR 1.8. recheck 6/14/19. Monitor closely..." There was no entry dated 6/14/19 on the	F757		

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F757	Continued From page 326 anticoagulant record and no evidence that a PT/INR was obtained on that date. There were two entries documented by ASM #10 (another nurse practitioner) dated 6/15/19 and 6/16/19 which documented the exact same information in the 6/11/19 note documented by ASM #7, including to re-check PT/INR on 6/14/19 although the date had past. The next PT/INR was obtained on 6/18/19 and was "26.9. INR: 2.2." "Action Taken By Physician: No (change). Re (check) 1 wk (week)." Further review of physician's orders failed to reveal a transcribed order to recheck the PT/INR in one week. The next PT/INR was obtained on 6/25/19 and was 26.1/2.2. Review of Resident #116's June 2019 MAR (medication administration record) revealed the resident was administered Coumadin per physician's orders during that month. On 8/6/19 at 10:54 a.m., Resident #116's anticoagulant record was reviewed with LPN (licensed practical nurse) #1. LPN #1 stated nurses are supposed to check the anticoagulant records every day at the beginning of the shift. LPN #1 stated she did not work 6/8/19 but on 6/10/19, she noticed Resident #116's PT/INR was not obtained on 6/8/19 because the columns on the anticoagulant record for that date was blank (LPN #1 stated she accidentally wrote in the 6/8/19 columns). LPN #1 stated she obtained a PT/INR on 6/10/19 and made the NP (nurse practitioner) aware the PT/INR was not done on 6/8/19. In regards to 6/14/19, LPN #1 confirmed a PT/INR was not obtained on that date although the physician/NP gave a directive to do so in the anticoagulant record. LPN #1 stated a PT/INR was then obtained on 6/18/19	F757		

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F757	Continued From page 327 and the NP was made aware. LPN #1 was asked if nurses are supposed to transcribe physician/NP directives from the anticoagulant record to physician's orders in the EHR. LPN #1 stated prior to the survey, nurses were not required to do so. When LPN #1 was asked if nurses are supposed to obtain PT/INRs per the physician/NP directives in the anticoagulant record, she stated, "Yes. It's nurses' responsibility to check the log (anticoagulant record) daily." On 8/6/19 at 11:23 a.m., an interview was conducted with ASM #3 (the director of nursing), regarding her role in Coumadin monitoring. ASM #3 stated the anticoagulant records were supposed to be reviewed during daily clinical operations meetings but that had not been "getting" done so now the records will be reviewed daily at the meetings to ensure orders for PT.INRs and Coumadin are written, transcribed and done. On 8/6/19 at 11:25 a.m., ASM #1 (the administrator), ASM #2 (the regional clinical coordinator) and ASM #3 were made aware of the above concern. No further information was presented prior to exit. (1) "Warfarin (Coumadin).This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a682277.html (2) "Prothrombin time (PT) -INR (international normalized ratio)." This information was obtained from the webiste: https://medlineplus.gov/ency/article/003652.htm	F757		

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F757	Continued From page 328 information was obtained from the website: https://vsearch.nlm.nih.gov/vivisimo/cgi-bin/query-meta?v%3Aproject=medlineplus&v%3Asources=medlineplus-bundle&query=dvt&_ga=2.137988019.2081124811.1565615930-1667741437.1550160688 3. The facility staff failed to provide Resident #527 with adequate monitoring for the administration of Coumadin (1), a high-risk medication. The physician/NP failed to identify any established therapeutic range for Resident #527's PT/INR (prothrombin time/international normalized ratio) (2) blood test results for the safe administration and monitoring of Coumadin. The facility staff failed to perform a PT/INR blood test on 7/20/19 as directed by the physician/NP (nurse practitioner) on the facility's Anticoagulant (3) Record. The facility staff failed to transcribe directives to increase Resident #527's Coumadin dosage on 7/17/19 to 3 mg (milligram) from the Anticoagulant Record into physician orders and Resident #527 received only Coumadin 2 mgs on 7/18/19 and 7/21/19. Staff also failed to transcribe the provider's directive for PT/INR monitoring from the Anticoagulant Record to Resident #527's EHR (electronic health record). Resident #527 was admitted to the facility on 7/12/19 with diagnoses including, but not limited to: broken rib, broken arm, broken hip which had been repaired by recent surgery, and a history of a DVT (deep vein thrombosis) (4) and PE (pulmonary embolism) (5). On the most recent MDS (Minimum Data Set), an admission assessment with an ARD (assessment reference date) of 7/19/19, Resident #527 was	F757		

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F757	Continued From page 329 coded as being severely cognitively impaired for daily decision making, having scored 3 out of 15 on the BIMS (brief interview for mental status). In Section N of this assessment, she was coded as receiving an anticoagulant on all seven days of the look back period. On 8/6/19 at 10:20 a.m., Resident #527 was observed in the therapy gym. Both arms were covered with clothing. There were no bruises or wounds visible on her hands. A review of the physician/NP recertification progress notes for Resident #527 for 7/12/19 until the survey dates failed to reveal any identification of a therapeutic range goal for Resident #527's PT/INR laboratory test results. Review of Resident #527's Anticoagulant Record (flowsheet maintained separately from the clinical record) revealed an entry on 7/17/19. In the column "Current Anticoagulant Drug and Dose," the record documented, "Warfarin (Coumadin) 3 mg MWF (Monday, Wednesday, Friday); Warfarin 2 mg T TH S S (Tuesday, Thursday, Saturday, Sunday)." The resident's PT/INR was documented as "22.2/1.9." In the column "Action Taken by Physician," the record documented, "3 mg QD (every day). Re [check] [PT/INR] 7/20." The next entry on the Anticoagulant Record was dated 7/22/19. The resident's PT/INR on 7/22/19 was documented as 30.5/2.5 (6). There was no documented evidence from the physician/NP directive on the Anticoagulant Record to obtain this laboratory test on 7/22/19. A review of Resident #527's EHR for July 2019 revealed there was no provider's order for this PT/INR on 7/22/19. A review of the EHR (electronic health record)	F757		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495109	A. BUILDING _____ B. WING _____	C 08/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LAURELS OF UNIVERSITY PARK	2420 PEMBERTON RD RICHMOND, VA 23233

(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) COMPLETE DATE
F757	Continued From page 330 for July 2019 for Resident #527 revealed no evidence that the PT/INR on 7/20/19 was obtained as directed on the 7/17/19 Anticoagulant Record. This record review revealed no evidence that the recommendation to perform a PT/INR on 7/20/19 was transcribed as an order into the EHR. Further, review of the resident's EHR for July 2019, revealed no evidence that the physician/NP directive to increase the Coumadin dosage from 2 mg to 3 mgs on 7/17/19 and was transcribed as an order into the EHR. Further review #527's EHR for July 2019 revealed no evidence that Resident #527's Coumadin dosage was increased to 3 mg daily as directed by the physician/NP on the Anticoagulant Record for 7/17/19. By way of nurses' initials on these dates, the MAR (medication administration record) documented that Resident #257 received Coumadin 2 mg at 5:00 p.m. on 7/18/19 (Thursday), and 7/21/19 (Sunday) instead of 3 mg as directed. A review of Resident #527's comprehensive care plan initiated on 7/12/19 revealed, in part, the following: "[Resident #527] is at risk for abnormal bleeding/bruising R/T (related to): medication use. Anticoagulant...Date Initiated: 8/1/19. Created on 8/1/19...Will have no signs of active bleeding through next review...Administer medications as ordered ...Obtain labs [laboratory tests] and diagnostics as ordered and report abnormal findings to the physician." On 7/31/19 at 2:36 p.m., an interview was conducted with ASM (administrative staff member) #5 (Resident #527's physician at the facility). ASM #5 was asked why Coumadin must be monitored. ASM #5 stated Coumadin	F757		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F757	Continued From page 331 (levels) could quickly become out of control because the medication can variably react with food and other medications. ASM #5 stated this is why the medication has to be monitored. ASM #5 was asked how often PT/INRs should be obtained to monitor Coumadin and stated that depends on the patient and other variables. When asked where staff document the monitoring of Coumadin and PT/INRs, ASM #5 stated they are documented in the Coumadin book (anticoagulant record). When asked how orders for Coumadin changes and PT/INRs are communicated, ASM #5 stated those are written in the anticoagulant record and she does not write actual orders for those. On 8/1/19 at 8:55 a.m., ASM #6, a nurse practitioner, was interviewed. When asked about the therapeutic INR range for a resident taking Coumadin for DVT prevention, she sated the said goal is usually 2 to 3. On 8/1/19 at 3:15 p.m., LPN (licensed practical nurse) #3 was interviewed. She stated she is a floor nurse who floats to various units, and that she usually works during the daytime shift (7:00 a.m. until 3:30 p.m.). She reviewed Resident # 527's Anticoagulant Records, providers' orders, MAR (medication administration record), TAR (treatment administration record), and laboratory administration record for July 2019. When asked if she saw evidence that the PT/INR had been obtained on 7/20/19 for Resident #527, she stated she could not. She stated the PT/INR "must not have been done" on 7/20/19. She stated she could identify her handwriting on both the 7/17/19 and the 7/22/19 Anticoagulant Record. She stated the recheck of the PT/INR was definitely not done on 7/20/19. When LPN #3 was asked if she saw evidence	F757		

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(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) COMPLETE DATE
F757	Continued From page 332 that the Coumadin had been increased to 3 mgs daily on 7/17/19, and that Resident #527 had received the Coumadin as directed, LPN #3 said she could not. LPN #3 stated, "I can't remember exactly, but I think [Resident #527] had an oncology appointment that day. Maybe the oncologist recommended something else. I don't know." When asked if she could find evidence in the clinical record to indicate that Resident #527 had seen an oncologist or that the oncologist had written an order for a change in the Coumadin dosage, she stated she could not. LPN #3 stated the flow sheet instructions were to give 3 mgs every day. She stated she would have discontinued the old order for Coumadin, and entered a new one for the new dosage. LPN #3 stated, "From what I see on the MAR, she did not get the 3 mgs every day until July 22nd." Since she was the nurse responsible for completing the Anticoagulant Record and making the changes in the orders, LPN #3 stated, "I probably thought I had done it, but I just did not." On 8/6/19 at approximately 7:55 a.m., ASM #7, a nurse practitioner, was interviewed. When asked about the normal therapeutic range for a patient taking Coumadin for a history of a DVT, she stated the therapeutic range is determined by the resident's diagnosis. On 8/6/19 at 10:18 a.m. administrative staff member (ASM) #2, the regional clinical coordinator, was asked what standard of practice the facility follows for the monitoring of anticoagulants, ASM #2 stated, "We follow our policies and Lippincott." "Coumadin: Maintaining Clotting Profiles: Prothrombin time (PT) and international normalized ratio (INR) are the coagulation tests	F757		

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F757	Continued From page 333 used to monitor the anticoagulation effects of Coumadin. The patient's INR should be 2 to 3.5 times the control. Note: the desired levels of the INR are determined by the health care provider. Obtain PT/INR levels daily or as ordered. Coumadin dose will be adjusted to achieve the desired level of anticoagulation. Preventing Bleeding: Have on hand the antidotes to reverse anticoagulants being used: Warfarin-phytonadione (vitamin K, AquaMEPHYTON). Patient Education and Health Maintenance: Instruct patient about taking anticoagulants. Follow instructions carefully and take medications exactly as prescribed; if a dose is missed, do NOT double up dose". This information is taken from Lippincott Manual of Nursing Practice. On 8/6/19 at 11:15 a.m., ASM (administrative staff member) #1, the administrator, ASM #2, the regional clinical coordinator, and ASM #3, the director of nursing, were informed of these concerns. No further information was provided prior to exit. (1) "Warfarin (generic for Coumadin) - This information is taken from the National Institutes of Health website https://medlineplus.gov/druginfo/meds/a682277.html. (2) "Prothrombin time (PT). This information is taken from the National Institutes of Health website https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5569083/. (3) Anticoagulant - "Anticoagulant...which means that it thins the blood, preventing blood clots from forming." This information is taken from the	F757		

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F757	Continued From page 334 (4) "Thrombosis is the medical term for the formation of a blood clot in a blood vessel. In deep vein thrombosis (DVT). This information is taken from the National Institutes of Health website https://www.ncbi.nlm.nih.gov/books/NBK425364/ . (5)"A pulmonary embolism (PE) is a sudden blockage in a lung artery. It usually happens when a when a blood clot breaks loose and travels through the bloodstream to the lungs." This information is taken from the National Institutes of Health website https://medlineplus.gov/pulmonaryembolism.html. (6) "The target levels of warfarin therapy are disease specific. A target therapeutic INR of 2.0 and 3.0 has long been considered as the safest range for DVT/PE. Achieving this range necessitates frequent monitoring and dose adjustment to prevent fatal consequences of hemorrhages and recurrent venous thrombosis/pulmonary embolism from either over or under anticoagulation." This information is taken from the National Institutes of Health website https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2887034/ 4. The facility staff failed to provide Resident #45 with adequate monitoring for the administration of Coumadin (1), a high-risk medication. The physician/NP failed to identify any established therapeutic range for Resident #45's PT/INR (prothrombin time/international normalized ratio) (2) laboratory test results. The facility staff failed to perform a PT/INR test as directed by the	F757		

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F757	Continued From page 335 physician/nurse practitioner directive to increase Resident #45's Coumadin dosage on 3/15/19 and 3/22/19, from the Anticoagulant Record into physician orders in Resident # 45's EHR (electronic health record). The directive on the Anticoagulant Record documented Resident #45 was to receive Coumadin 3.5 milligrams (mgs) daily starting 3/15/19, and Coumadin 4 mg daily starting 3/22/19, and Resident #45 received only Coumadin 3 mgs daily from 3/15/19 through 3/26/19 (except for 3/19/19, when the medication was held). The facility staff also failed to transcribe the provider's directive for PT/INR tests and monitoring from the Anticoagulant Record to Resident # 45's EHR (electronic health record) on multiple dates in September and November 2018, and in January, February, March, and June of 2019. Resident #45 was admitted to the facility on 12/14/13, with diagnoses that included, but not limited to, a history of a stroke, and the presence of a prosthetic (artificial) heart valve. On the most recent MDS (Minimum Data Set), a quarterly assessment with the ARD (assessment reference date) of 5/6/19, Resident #45 was coded as having no cognitive impairment for daily decision making, having scored 15 on the BIMS (brief interview for mental status). In section N of this assessment, he was coded as having received an anticoagulant on all seven days of the look back period. On 8/6/19 at 10:15 a.m., Resident #45 was observed lying on his back in bed. His eyes were closed. There was no bruising and there were no wounds visible on his skin. A review of the physician/NP recertification progress notes for Resident #45 from November 2018 through June 2019 failed to reveal any	F757		

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F757	Continued From page 336 identification of a therapeutic range goal for Resident #45's PT/INR blood test results. A review of Resident #45's Anticoagulant Record revealed an entry on 8/1/18. In the column "Action Taken by Physician," the record documented the resident's PT/INR on 8/1/18 as 29.8/2.5. Under the "Action Taken by Physician", the following was documented, "[No change]. Re [check] [PT/INR] in 3." A review of Resident #45's nurses' note dated 8/2/18 revealed, in part, the following: "New order for Coumadin (sic) 5mg recheck PT/INR IN 3 WEEKS left message for RP (responsible party)." The next entry on the Anticoagulant Record was dated 8/22/18. There was no information in any of the columns for this date; the entire line was blank. Further review of the Anticoagulant Record revealed an entry on 8/31/18 the Anticoagulant Record documented in part, the residents PT/INR as "96/8". (4) Under "Action Taken by Physician: "hold X 4d (days) recheck on 9/4." The INR was obtained as directed on 9/4/18. A review of the EHR (electronic health record) for August 2018 for Resident #45 revealed no evidence that the PT/INR directed by the physician/NP on 8/1/18 on the Anticoagulation record, and documented in the 8/2/18 nurses' note, was ever completed on 8/22/18. This record review revealed no evidence that the physician/NP directive to perform a PT/INR on 8/22/18 was transcribed as an order into the EHR and there was no documented order to obtain a PT/INR test on 8/31/18. A review of Resident #45's comprehensive care	F757		

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F757	Continued From page 337 plan dated 11/23/17 revealed, in part, the following: "BLEED101: At risk for abnormal bleeding/bruising R/T (related to)anticoagulation use ...Date Initiated: 11/23/17. Created on 11/23/17...Will have no signs of active bleeding...Administer medications as ordered ...Obtain labs as ordered. Report abnormal findings to the physician." On 7/31/19 at 2:36 p.m., an interview was conducted with ASM (administrative staff member) #5 (Resident #45's physician at the facility). ASM #5 was asked why Coumadin must be monitored. ASM #5 stated Coumadin (levels) could quickly become out of control because the medication can variably react with food and other medications. ASM #5 stated this is why the medication has to be monitored. ASM #5 was asked how often PT/INRs should be obtained to monitor Coumadin. ASM #5 stated that depends on the patient and other variables. When asked where staff document the monitoring of Coumadin and PT/INRs, ASM #5 stated they are documented in the Coumadin book (anticoagulant record). When asked how orders for Coumadin changes and PT/INR tests are communicated, ASM #5 stated those are written in the anticoagulant record and she does not write actual orders for those. On 8/1/19 at 8:55 a.m., ASM #6, a nurse practitioner, was interviewed. When asked about the therapeutic INR range for a resident taking Coumadin for DVT prevention, she sated the said goal is usually 2 to 3. On 8/6/19 at approximately 7:55 a.m., ASM #7, a nurse practitioner, was interviewed. When asked about the normal therapeutic range for a patient taking Coumadin for a history of a DVT, she stated the therapeutic range is determined	F757		

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F757	Continued From page 338 by the resident's diagnosis. On 8/6/19 at 10:25 a.m., LPN (licensed practical nurse) #1 was interviewed regarding these findings. LPN #1 reviewed Resident #45's Anticoagulant Record, providers' orders, and laboratory test records for August 2018. When asked if she could find any evidence that Resident #45 received a PT/INR on 8/22/18, LPN #1 stated she could not. When asked if this was concerning for the patient, LPN #1 stated, "Oh yes. The PT and INR need to be done as they are written in the book (anticoagulant record)." When asked why this is important, she stated, "The patient's blood could be too thick or too thin. We have to know from the test." She stated that, in looking at the Anticoagulant Flow Sheet, it appeared that on 8/31/18, she was caring for Resident #45 and realized the 8/22/18 PT/INR had not been done, and she went ahead and performed the test on 8/31/18. Further review of Resident #45's Anticoagulant Record revealed an entry on 3/15/19. In the column "Current Anticoagulant Drug and Dose," the record documented, "3 mg." In the column "Action Taken by Physician," the record documented: "[Increase Coumadin] 3.5 mg (milligrams) QD (every day). Recheck [PT/INR] 3/22." A review of the nurse practitioner's note written by ASM #7 for Resident #45 dated 3/15/19 revealed, in part, the following: "INR: 1.9. DX (diagnosis): prosthetic heart valve. Previous Order Coumadin: 3 mg daily. New Order Coumadin: 3.5 mg. Recheck date: 3/22/19." A review of Resident #45's EHR for March 2019 revealed no evidence that Resident #45's Coumadin dosage was increased to 3.5 mg daily	F757		

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F757	Continued From page 339 as directed by the physician/NP on the Anticoagulant Record. There was no evidence the directive on 3/15/19 to increase the Coumadin to 3.5 mg had been transcribed to a physicians order in the EHR. The PT/INR results for the next test date, 3/22/19, were 20.5/1.7. A review of Resident #45's Anticoagulant Record revealed an entry on 3/22/19. In the column "Current Anticoagulant Drug and Dose," the record documented, "3.5 mg." In the column "Action Taken by Physician," the record documented: "[Increase Coumadin] 4 mg QD. Recheck [PT/INR] 4/3." A review of Resident #45's EHR for March 2019 revealed no evidence that Resident #45's Coumadin dosage was increased to 4 mg daily, as directed by the physician/NP on the Anticoagulant Record, until 3/27/19. There was no evidence the directive on 3/22/19 to increase the Coumadin to 4 mg had been transcribed to a physicians order in the EHR. The PT/INR results for the next test date, 4/3/19, were 32.9/2.7. Further review of Resident #45's March 2019 MAR (medication administration record) revealed, by way of nurses' initials on these dates, that the resident received Coumadin 3 mg by mouth each day from 3/15/19 through 3/26/19. The review of the MAR also revealed that the resident received Coumadin 4 mg daily from 3/27/19 through the end of the month. On 8/6/19 at 10:25 a.m., LPN #1 was interviewed regarding these findings. LPN #1 reviewed Resident #45's Anticoagulant Record, providers' orders, and MAR (medication administration record) for March 2019. When asked if she could find evidence to verify that Resident #45's Coumadin dosages were	F757		

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F757	Continued From page 340 increased as directed in the Anticoagulant record on 3/15/19 and 3/22/19, LPN #1 stated she could not. When asked the significance of the lack of evidence, LPN #1 stated, "It looks like we missed these increases. I don't think the medication was given like it was supposed to be. I don't see anything else." A review of Resident #45's Anticoagulant Record revealed that on the following dates, point of care blood tests for PT/INR were performed: 9/4/18, 9/20/18, 11/15/18, 11/23/28, 1/24/19, 2/21/19, 3/15/19, 3/22/19, and 6/26/19. A review of Resident #45's EHR for the above referenced dates in 2018 and 2019 revealed no evidence that these tests were transcribed from the directive on the Anticoagulant Record to providers' orders. On 8/6/19 at 10:18 a.m. administrative staff member (ASM) #2, the regional clinical coordinator, was asked what standard of practice the facility follows for the monitoring of anticoagulants, ASM #2 stated, "We follow our policies and Lippincott." On 8/6/19 at 10:25 a.m., LPN #1 was interviewed regarding these findings. LPN #1 reviewed Resident #45's Anticoagulant Record, providers' orders, and MAR for the above referenced dates in 2018 and 2019. When asked if the directives on the Anticoagulant Record should be transcribed to a provider's order, she stated, "Well, that's not how we were doing it before [this survey], but I know it's how we should have been doing it. We are doing it now." On 8/6/19 at 11:15 a.m., ASM (administrative staff member) #1, the administrator, ASM #2,	F757		

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	495109	A. BUILDING _____ B. WING _____	C 08/07/2019

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F757	Continued From page 341 the regional clinical coordinator, and ASM #3, the director of nursing, were informed of these concerns. No further information was provided prior to exit. (1) Coumadin (generic name Warfarin) - This information is taken from the National Institutes of Health website https://medlineplus.gov/druginfo/meds/a682277.html. (2) "Prothrombin time (PT) and international normalized ratio (INR)." This information is taken from the National Institutes of Health website https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5569083/. (3) Anticoagulant - This information is taken from the National Institutes of Health website https://ghr.nlm.nih.gov/condition/warfarin-resistance. (4) "After aortic valve replacement (AVR) with mechanical prostheses, warfarin is indicated to achieve an INR of 2.0 to 3.0. If the patient has risk factors, warfarin is indicated to achieve an INR of 2.5 to 3.5 ...After mitral valve replacement (MVR) with mechanical valve, is indicated warfarin to achieve an INR of 2.5 to 3.5." This information is taken from the National Institutes of Health website https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3835169 5. The facility staff failed to ensure Resident #189 received adequate monitoring for the use of Coumadin, an anticoagulant (a blood thinning medication), to ensure appropriate	F757		

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F757	Continued From page 342 ratio) per the physician order on 4/12/19, 6/27/19 and 7/26/19 and per documented directives on the anticoagulant record on 5/1/19. Staff failed to administer transcribe physician/nurse practitioner directives from the Anticoagulant Record into orders resulting in the resident receiving the wrong dose of Coumadin, medication being held without orders, and Coumadin being administered instead of held as directed which, resulted in Resident #189 receiving unnecessary doses of Coumadin. The facility staff failed to transcribe physician orders for PT/INR levels rechecks and doses changes of Coumadin, into the electronic medical record (EMIR) and physician's orders. Resident #189 was admitted to the facility on 9/16/17 with a most recent readmission on 7/16/19 diagnoses included but were not limited to: mechanical heart valve, stroke, high blood pressure and atrial fibrillation. (Atrial fibrillation is a condition characterized by rapid and random contraction of the atria of the heart causing irregular beats of the ventricles and resulting in decreased heart output and frequently clot formation in the atria) (1). The most recent MDS (minimum data set) assessment, a Medicare five day admission, with an assessment reference date of 7/23/19, coded the resident as scoring an "11" on the BIMS (brief interview for mental status score) indicating the resident was moderately impaired to make daily decisions. In Section N - Medications, the resident was coded as receiving an anticoagulant for the seven days of the look back period. *Coumadin is an anticoagulant/blood thinner that keeps your body from forming blood clots. (2)	F757		

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F757	Continued From page 343 The comprehensive care plan dated, 12/19/18 and revised on 3/7/19, documented in part, "Focus: (Resident #189) is at risk for abnormal bleeding/bruising R/T (related to) medication use, anticoagulant diagnosis of A-Fib (atrial fibrillation), stroke." The "Interventions" documented in part, "Administer medications as ordered. Observe for ineffectiveness and side effects, report abnormal findings to the physician. Obtain labs (laboratory) and diagnostics as ordered and report abnormal findings to the physician. Observe and report to physician PRN (as needed) s/sx (signs and symptoms) of complications: blood tinges/frank blood in urine, black tarry stools, dark or bright red blood in stools, sudden severe headaches, nausea, vomiting, diarrhea, muscle joint pain , lethargy, bruising, blurred vision, SOB (shortness of breath), loss of appetite, sudden changes in mental status, significant or sudden changes in v/s (vital signs - blood pressure, heart rate, respirations), bleeding gums, petechiae (tiny reddish or purple flat spot appearing on the skin as the results of tiny hemorrhages within the skin or subcutaneous layers) (3), back or abdominal pain and nosebleeds." The nurse practitioner note dated, 8/10/18, documented, "INR goal 2.5 - 3.5." "Prothrombin time (PT) is a blood test that measures the time it takes for the liquid portion (plasma) of your blood to clot." "PT is measured in seconds. Most of the time, results are given as what is called INR (international normalized ratio)." "The most common reason to perform this test is to monitor your levels when you are taking a blood-thinning medicine called warfarin [Coumadin]. You are likely taking this medicine to prevent blood clots. Normal Results: PT is	F757		

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F757	Continued From page 344 measured in seconds. Most of the time, results are given as what is called INR (international normalized ratio). If you are taking warfarin to prevent blood clots, your provider will most likely, choose to keep your INR between 2.0 and 3.0." (4) The physician directive on the "Anticoagulant Record" dated, 7/23/18, documented, "Restart 4 mg (milligrams) qd (everyday)." Resident #189's "Anticoagulant Record" dated 7/30/18, documented the current dose of Coumadin as 4 mg (milligram). The INR was documented as 2.5. There was no documentation on the "Anticoagulant Record" that the physician was notified of the INR. There was no nurse's note documented and no nurse practitioner or physician notes on 7/30/18. On 7/31/18, the "Anticoagulant Record" documented the current dose of Coumadin as 4 mg, INR 2.1, [below the INR goal 2.5 - 3.5 placing the resident at risk of blood clots]. The physician directive documented, "Increase [Coumadin] to 4.5 mg qd [every day] recheck in 3 days 8/3/18." The order for the increase in Coumadin dosage was transcribed into the EMR (electronic medical record). A nurse practitioner note dated, 7/31/18, documented in part, "INR review: Anticoagulated with Coumadin. INR goal 2.5 - 3.5. INR today 2.1 on 4 mg qd. Will increase to 4.5 mg ....." On 8/10/18, Resident #189's "Anticoagulant Record" documented the current Coumadin dose as "4.5 mg", INR "1.4", [below the identified INR goal]. The "Anticoagulant Record" documented the physician was notified on 8/10/18 and documented the following physician	F757		

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F757	Continued From page 345 directive, "Increase to 5 mg qd [every day] and recheck 8/13/18. A nurse practitioner note dated, 8/10/18, documented in part, "Patient is on anticoagulation for a fib and prosthetic heart valve. Goal INR 2.5 - 3.5. INR today is 1.4 on 4.5 mg Coumadin. Will increase to 5 mg daily and recheck INR on 8/13/18." There was no physician order for the increase in Coumadin or the repeat PT/INR documented above in the EMR. The MAR (medication administration record) for August 2018, documented the dose change of "Coumadin 5 mg qd." Further review of the "Anticoagulant Record" revealed an entry with the date 8/15/18 written and crossed off and the date 8/13/18 entered. The entry on 8/13/18, documented the current dose of Coumadin as "5 mg", the INR level obtained was documented as "1.4" [below the INR goal of 2.5 - 3.5]. The physician was notified on 8/13/18. The physician directive documented, "Increase dose [Coumadin] to 5.5 mg recheck INR 8/17/18." There was no documented physician order transcribed in the EMR to increase the dose of Coumadin to 5.5 mg, and no order to recheck the INR on 8/17/18. Review of the August 2018 MAR documented the physician directive dated, 8/10/18 for, "Coumadin 5 mg; give 1 tablet in the evening related to unspecified atrial fibrillation." The August MAR documented the resident received Coumadin 5 mg on 8/13/18 and 8/14/18, instead of the 5.5 mg as documented under the physician directive above on anticoagulant log for 8/13/18.	F757		

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F757	Continued From page 346 On 8/15/18, Resident #189's documented INR on the Anticoagulant record was 1.8, [below the documented INR goal of 2.5 - 3.5 placing the resident at risk for blood clots]. The current Coumadin dose was documented as "5 mg [milligrams]" [instead of the 5.5 mg previously directed on 8/13/18], the physician directive documented, "Increase to 5.5 mg recheck 8/18/18. Review of the EMR (electronic medical record) revealed a documented physicians order was transcribed for the increased dose of Coumadin dated 8/15/18. Review of the August 2018 MAR revealed the documented order for "Coumadin 5.5 mg by mouth in the evening, effective 8/15/18." Further review revealed a "5" was documented for the dose of Coumadin due on 8/15/18. A "5" per the MAR indicated to "Hold/see nurse's notes." A review of the EMR [electronic medical record] failed to evidence a nurse's note for 8/15/18. Thus, the resident did not receive any Coumadin on 8/15/18, as per the physician order. There was no documentation evidencing the physician was notified Resident #189's Coumadin was held on 8/15/18. The resident's INR on the "Anticoagulant Record" dated; 8/17/18 was documented as "1.6", below the documented INR goal of 2.5 - 3.5 placing the resident at risks for blood clots. Resident #189's "Anticoagulant Record" revealed an entry with the date of 8/18/18, that was crossed off and the date 8/17/18 entered. The entry for 8/17/18 documented the current Coumadin dose of "5.5 mg", INR obtained as "1.6", [below therapeutic range, and was completed on 8/17 instead of 8/18/18 without a physician's order or directive]. The "Anticoagulant Record" record documented, the physician was notified on 8/18/18, and under	F757		

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F757	Continued From page 347 action taken by physician, "Same dose, recheck on 8/20/18." A nurse's notes dated 8/18/18 at 12:51 p.m., documented, "Guest PT 19, INR 1.6. New order to recheck 8/20/18 - cont (continue) 5.5 mg verbal order." On 8/20/18, the "Anticoagulant Record" documented the current Coumadin dose of "5.5 mg", the INR obtained was "INR 1.8", [below therapeutic range placing the resident at risk for blood clots], the physician was notified on 8/20/18, and under the heading "Action Taken by Physician," "resident was sent out for acute neurological changes." A nurse's note dated, 8/25/18, documented, "Guest returned to facility on 8/24/18." A physician progress note dated, 8/26/18 documented in part, "Readmission: s/p (status post) CVA (stroke) with vision loss - on ASA (aspirin) and Coumadin...Atrial Fibrillation - stable. On Coumadin. Pertinent Lab (laboratory) Data/Test Results: 8/24/18 INR 2.4." A physician order in the EMR dated, 8/24/18, documented "Coumadin 5.5 mg by mouth in the evening." There was no physician order to recheck Resident #189's PT/INR in the EMR (electronic medical record). On the "Anticoagulant Record" dated, 8/27/18, the current Coumadin dose was documented as "5.5 mg", the INR was obtained and was documented as "5.8" [this was obtained without a physician/directive or order and was above therapeutic range, putting the resident at risk for bleeding]. The doctor was notified on 8/27/18. Documented under "Action Taken By Physician" was, "Hold today, recheck 8/28/18."	F757		

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F757	Continued From page 348 Review of the EMR failed to evidence a physician's order was transcribed to hold Resident #189's Coumadin on 8/27/18. Review of the August MAR revealed the 8/24/18, order for Coumadin 5.5 mg and an "H" indicating, "Hold" documented on 8/27/18 for the 5.5 mg dose of Coumadin on that date. A nurse's note dated, 8/27/18 at 3:17 p.m. documented, "Guest Coumadin is on hold per md (medical doctor) ...nurse will recheck pt/inr on 8/28." On 8/28/18, the "Anticoagulant Record", documented the current Coumadin dose as "Hold". The INR was checked, as was, "5.2", [above the documented therapeutic goal of 2.5-3.5 putting the resident at risk for bleeding]. The physician was notified on 8/28/18, the physician directives documented, "Hold recheck 8/30/18." There was no documented physician order transcribed in the EMR to hold Resident #189's Coumadin on 8/28/18. Review of the August 2018 MAR revealed the 8/24/18, order for Coumadin 5.5 mg and an "H" indicating, "Hold" documented on 8/28/18 for the 5.5 mg dose of Coumadin on that date. A nurse's note dated, 8/28/18 at 2:16 p.m. documented in part, "PT 62.5, INR 5.2, continue to hold Coumadin, recheck INR 8/29/18. The nurse practitioner note dated, 8/28/18, documented in part, "On Coumadin: INR today 5.2. Hold Coumadin x 1 and recheck 8/29/18. There was no documented physician order transcribed into the EMR to hold Resident #189's Coumadin on 8/29/18. On 8/29/18, the "Anticoagulant Record"	F757		

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F757	Continued From page 349 documented the current Coumadin dose as "HOLD," The INR was obtained and was "3.5", the physician was notified on 8/29/18. The physician directive documented, "Hold x 1 d (8/29/18), start (Coumadin) 4 mg qd [everyday] (8/30/18) and recheck in 1 wk (week) (9/5/18)." A review of the EMR failed to evidence a physician's order to hold the Coumadin for Resident #189, for one day on 8/29/18, or an order for the physician's directive on the "Anticoagulant Log" to start the Coumadin 4 mg on 8/30/18. The MAR for August 2018 failed to evidence that Resident #189 received any Coumadin on 8/30/18 and 8/31/18 per the 8/29/18, documented physician directive above. The September 2018 MAR failed to document the 8/29/18 physician's directive on the "Anticoagulant Record" for Coumadin 4 mg qd (every day) to start on 8/30/18. The MARs failed to evidence that Resident #189 received any Coumadin on 9/1/18, 9/2/18, 9/3/18, and 9/4/18. There were no nurse's note related to the Coumadin or PT/INR levels from 8/29/18 through 9/4/18. The next documented INR level was on 9/5/18 at 1.1 [below the identified goal level placing the resident at risk for the development of blood clots]. Review of the EMR failed to evidence any documentation related to the resident not receiving the Coumadin on the above dates. The "Anticoagulant Record" dated 9/5/18, documented the current Coumadin dose of "4 mg", INR results "1.1" [below therapeutic range], the physician was notified on 9/5/18, The "Action By The Physician" documented, "Increase [Coumadin] to 4.5 mg qd [everyday] and recheck	F757		

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F757	Continued From page 350 9/7/18." The directive for the Coumadin dose increase to 4.5 mg (milligrams) was transcribed into the EMR as an order dated 9/5/18. The nurse practitioner note dated 9/5/18, documented in part, "Sub therapeutic INR - 1.1 on 4 mg Coumadin daily...On Coumadin, INR 1.1 today. Will increase dose to 4.5 mg daily and recheck 9/7/18." The note failed to evidence any documentation regarding the resident not receiving Coumadin for six days on 8/30/18, 8/31/18, 9/1/18, 9/2/18, 9/3/18, and 9/4/18. On 9/27/18, the "Anticoagulant Record" documented the current Coumadin dose as "On Hold," "INR1.6" [below therapeutic goal level]. The physician directive documented, "5 mg (Coumadin) check 10/1/18." A physician order was transcribed into the EMR dated 9/27/18 and documented to increase the Coumadin to 5 mg. Review of the September MAR, also documented the order for Coumadin 5 mg. The order was transcribed to start on 9/28/18. Further review of the MAR failed to evidence the resident received any Coumadin on 9/27/18, per the physician directive and physician order dated 9/27/18 in the EMR. There was no documentation evidencing the physician was notified Resident #189's Coumadin was held on 9/27/18. On the 11/15/18 "Anticoagulant Record" revealed the date 11/15/18, was written and crossed off and the date 11/14/18 entered, and documented the current Coumadin dose as "4.5 mg", the INR was obtained and the level was documented as "INR 2.6", the physician was not notified until 11/15/18. The physician directive documented, "increase to 5 mg qd [every day]	F757		

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F757	Continued From page 351 and recheck 11/19/18." A nurse practitioner note dated, 11/15/18, documented in part, "INR review. INR today 2.2. [Incorrect level] On Coumadin 4.5 mg for MVR [Mitral valve replacement] and a fib. Goal 2.5 - 3.5. On Coumadin. Increase to 5 mg qd and recheck on 11/19/18." Review of the EMR revealed a physician order dated 11/15/18to increase the Coumadin to 5 mg. Review of the November 2018 MAR revealed an "H" indicating hold documented under the date 11/15/18, for the 4.5 mg dose of Coumadin evidencing Resident #189 did not receive any Coumadin on this date. Review of the nurse's notes failed to evidence any note for 11/15/18 and there was no documentation evidencing the physician was notified Resident #189's Coumadin was held on this date. The new order for Coumadin 5 mg was documented on the MAR with a start date of 11/16/18. The next INR documented on the "Anticoagulant Record" was dated, 11/19/18 and documented Resident #189's INR was 3.2. The "Anticoagulant Record" dated, 1/9/19, documented the current "Coumadin dose as "5 mg", INR level "4.0" [above therapeutic goal], the physician was notified on 1/9/19. The physician directive documented, "Hold Coumadin, recheck 1/10/19." There was a physician order transcribed into the EMR to hold the Coumadin and to recheck the PT/INR on 1/10/19. On 1/10/19, the "Anticoagulant Record" documented the current Coumadin dose as "HOLD" INR level obtained as "2.8." The	F757		

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	495109	A. BUILDING _____ B. WING _____	C 08/07/2019

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F757	Continued From page 352 physician directive documented, "(Coumadin) 4.5 mg qd (every day), recheck 1/15/19. Physician orders were transcribed into the EMR for the above directives. The January 2019 MAR documented the following order, "Coumadin 2.5 mg; give 1 tablet by mouth in the evening for A fib to give with 2 mg to make 4.5 mg." Further review of the January 2019 MAR failed to evidence the resident received any Coumadin on 1/10/19. The order was transcribed to start on 1/11/19 and not 1/10/19 as ordered. There was no documentation evidencing the physician was notified Resident #189's Coumdain was held on 1/10/19. On 1/15/19, the "Anticoagulant Record" failed to evidence an INR level was completed as directed. Under the INR column, it documented N/A (not applicable) Drawn per lab. On 1/16/19, the "Anticoagulant Record" documented the current Coumadin Dose of 4.5 mg. Under the INR column, it documented, "Drawn per lab." There was no documented date indicating notification to the doctor/nurse practitioner. Under the "Action Taken by Physician" column, it documented, "Increase to 5 mg recheck 1 wk [week] 1/23/19". There was no nurse practitioner or physician note on 1/15/19. On 3/6/19, the "Anticoagulant Record" documented the current Coumadin dose as "5 mg". The INR obtained was documented as "5.1." There were no test strip lot numbers documented as well as no documentation under the "Quality Control Test," if it was successful for QC or error noted." The physician directive documented, "No change recheck 4/3/19."	F757		

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F757	Continued From page 353 The manufacturer's "User Manual" documented in part, "Code Strip: Each box of test strips comes with its own code chip. The code chip provides the meter with information such as the lot number and expiration date of the test strips. Before each test, make sure the correct code chip is in the meter. Each time you open a new box of test strips, replace the old code chip with the new one. Protect the code chip from moisture and also equipment that produces magnetic fields, such as a microwave oven. Make sure that the three-number code on the new test strip container matches the three-number code on the new code chip. Slide the new code chip into the code chip slot until it snaps into place. The CoaguChek XS System has quality control functions integrated into the meter and the test strips, so you never have to run quality control tests with liquid quality controls. The meter automatically runs its own quality control test as part of every blood test. When the quality control test runs, the letters QC flash on the meter's display. When the quality control test completes, a check mark, appears following the letters QC. Then the meter continues to run the blood test. If the quality control test fails, the meter displays the ERROR message." A request was made on 8/5/19 to administrative staff member (ASM) #1, the administrator, for the copies of the PT/INR results for Resident #189 on 1/15/19 and 1/16/19. None were provided prior to exit. A nurse's note dated, 4/9/19 at 6:41 p.m. documented in part, "Guest readmitted to facility after short stay at (initials of hospital). Last PT/INR reading was today 19.2 and 1.6."	F757		

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F757	Continued From page 354 A physician note dated, 4/10/19, documented in part, "Readmitted from (initials of hospital). Under "Pertinent Lab Data/test Results," the PT/INR was not documented. Under A/P (approach/plan) was documented, "Atrial Fibrillation - stable - rate controlled. Continue POC (plan of care). On Coumadin. Monitor closely. Hx (history) mitral valve replacement; on Coumadin. Plan as above." There was no order entered into the EMR for Coumadin until 4/10/19. On 4/10/19 the order documented Coumadin 2.5 mg by mouth in the evening." The April 2019 MAR documented an order for Coumadin from 1/16/19, "Coumadin 5 mg by mouth in the evening." The MAR documented the resident received Coumadin 5 mg on 4/9/19. The MAR further documented on 4/10/19, "Coumadin 2.5 mg by mouth in the evening." This order was initiated on 4/10/19. On 4/11/19, the "Anticoagulant Record" documented the current Coumadin dose as "2.5 mg" The INR was obtained and documented as, "2.3", [below therapeutic goal placing the resident at risk for blood clots for a level too low and bleeding for a level to high]. There were no test -strip lot numbers, documented and no documentation under the "Quality Control Test," if it was successful for QC or error noted. The physician directive documented, "No change recheck in one day." A physician order dated, 4/11/18 in the EMR documented, "Recheck PT/INR level on 4/12/19. On 4/12/19, the "Anticoagulant Record" failed to evidence the PT/INR test was obtained as ordered. The form documented the current Coumadin dose documented as "2.5 mg" but the rest of the line was empty. Review of the nurse's	F757		

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F757	Continued From page 355 note failed to evidence a nurse's note for 4/12/19. The test was not completed per the physician order dated 4/11/19 in the EMR and the physician directive documented on the "Anticoagulant Record." The delay in monitoring reflected an ineffective system in place for safe administration of the medication. Review of the physician's orders in the clinical record revealed an order dated 4/24/19 that documented 6 mg of Coumadin every day. The April 2019 MAR documented that the resident received the Coumadin 6 mg on 4/24/19. On the "Anticoagulant Record" dated, 4/25/19, the current Coumadin dose was documented as "6 mg". The PT/INR obtained was documented as "2.2" [below the identified goal of 2.5-3.5 placing the resident at risk for clots]. The physician directive on the record documented, no change recheck on 4/27/19. Review of the April MAR failed to evidence the resident received the prescribed dose of Coumadin, 6 mg on 4/25/19. There was no physician order in the clinical record to hold Resident #189's Coumadin on 4/25/19. There was no documentation evidencing the physician was notified Resident #189's Coumadin was held on 4/25/19. The PT/INR was obtained on 4/27/19 as directed. On 4/30/19, the "Anticoagulant Record" documented the current Coumadin dose as "6 mg", The INR obtained was, "1.9" [below therapeutic goal], the physician directive documented, "Coumadin 5 mg, recheck 5/1/19." There was a documented physician order transcribed into the EMR (electronic medical record) for the Coumadin 5 mg. On the "Anticoagulant Record" dated, 5/1/19,	F757		

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F757	Continued From page 356 the line was blank. There was no documentation on this line. The next entry dated, 5/2/19, documented the current Coumadin dose as "5 mg"; the INR obtained was documented as "1.6" [below therapeutic goal]. The physician directive documented, "Coumadin 5.5 mg. recheck." A physician order dated, 5/2/19 was transcribed into the EMR documented, "Coumadin 5.5 mg, give by mouth every evening." On 5/4/19, the "Anticoagulant Record" documented the current Coumadin dose as "5.5 mg"; the INR was obtained and was documented as "2.3". There was no documented physician notification or documentation of any action taken by the physician. There was no nurse's, nurse practitioner or physician note dated 5/4/19. The "Anticoagulant Record" dated, 5/8/19, failed to evidence documentation of the resident's current Coumadin dose. The INR obtained was documented as "4.6". There was no name of the nurse completing the test, no test-strip lot number, and nothing documented under the Quality Control Test - successful QC or Error noted. The physician directive documented, "Hold x 1 recheck 5/9/19." A nurse practitioner note dated, 5/8/19, documented in part, "Elevated INR of 4.6. Hold x 1 and recheck 5/9/19. Review of the EMR failed to evidence a physician's order to hold the Coumadin on 5/8/19. The May 2019 MAR documented the directive on the "Anticoagulant Record" for "Coumadin 5.5mg". On 5/8/19, the MAR documented the Coumadin 5.5 mg was administered to Resident #189, when the	F757		

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F757	Continued From page 357 physician directive on the "Anticoagulant Record" documented to hold it on 5/8/19. On 5/9/19, Resident #189's "Anticoagulant Record" failed to document the resident's current Coumadin order. The INR obtained was documented as "4.3" [above the identified goal placing the resident at risk for bleeding]. There was no documentation of the date and initials of when the physician was notified. Under "Action Taken by physician" the following was documented, "Hold x 1 recheck 5/10/19." There were physician orders transcribed into the EMR to hold the Coumadin (on 5/9/19) and to recheck the PT/INR on 5/10/19. The "Anticoagulant Record" dated, 5/10/19, documented the resident's current Coumadin dose as "HOLD." The INR obtained was documented as "4.7" [above the identified goal of 2.5-3. 5]. There were no name of the nurse completing the test, no test-strip lot number, and nothing documented under the Quality Control Test - successful QC or Error noted. There was no documentation of physician notification. The physician directive documented, "Hold today and recheck 5/11/19". A nurse practitioner note dated, 5/10/19, documented in part, "Elevated INR of 4.7. On Coumadin 5.5 mg qd - held x 2 day due to elevated INR. INR 4.7 today - Hold x 1 and recheck 5/11/19." There was no nurse's note dated, 5/10/19. There was no transcribed physician order to hold the Coumadin on 5/10/19, in the EMR. The May 2019 MAR documented "Coumadin 5.5.mg" and documented that the Coumadin 5.5	F757		

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F757	Continued From page 358 mg was administered to Resident #189 on 5/10/19, when the physician directive on the "Anticoagulant Record" documented to hold the Coumadin. On 5/12/19, the "Anticoagulant Record" documented the current Coumadin dose as "5.5 mg". The INR obtained was documented as "2.8". The physician directive documented, "Decrease (Coumadin) to 3 mg, recheck 1 wk." A physician order in the EMR dated, 5/12/19, documented, "Coumadin 3 mg by mouth in the evening for anticoagulation." The order was transcribed to the May 2019 MAR. The MAR documented the order was to start on 5/13/19, and not 5/12/19 as ordered. The resident did not receive any Coumadin on 5/12/19. There was no physician or nurse practitioner note dated, 5/12/19. There was no nurse's note dated, 5/12/19. There was no documentation evidencing the physician was notified Resident #189's Coumdain was held on 5/12/19. On 5/20/19, the "Anticoagulant Record" documented the current Coumadin dose as "3 mg"; the INR obtained was "1.6" [below the therapeutic goal]. The physician directive documented, "Increase to 4 mg, recheck 1 wk." A physician order in the EMR dated, 5/20/19 documented, "Coumadin 4 mg; give 1 tablet by mouth in the evening for prevent dvt (deep vein thrombosis)." The May MAR documented the physician order for Coumadin 4 mg. The order on the MAR was documented to start on 5/21/19 and not 5/20/19 as ordered. Further review of the MAR failed to evidence the resident received any Coumadin on 5/20/19. There was no documentation evidencing the physician was notified Resident #189's Coumadin was held on	F757		

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F757	Continued From page 359 5/20/19. On 6/26/19, the "Anticoagulant Record" documented the current Coumadin dose as "5.5 mg". The INR obtained was documented as "4.3" [higher than the identified goal]. The physician directive documented, "Hold x1, recheck 6/27/19." Review of the EMR revealed documented physician orders dated 6/27/19 to hold the Coumadin and recheck on 6/27/19. A nurse practitioner note dated, 6/26/19, documented in part, "INR today 4.6. On Coumadin 5.5.mg qd. (every day), goal 2.5 - 3.5, hold x 1 and recheck 6/27/19." On 6/27/19, the "Anticoagulant Record" failed to evidence documentation of the INR as ordered, evidencing a delay in monitoring. On 6/28/19 the "Anticoagulant Record" documented, the obtained INR was "1.7" [below the identified therapeutic goal placing the resident at risk for blood clots]. There were no physician and/or nurse practitioner notes from 6/26/19 through 7/5/19. There were no nurse's notes for 6/26/19 through 6/28/19. On 7/18/19, the "Anticoagulant Record" documented in part, the physician directive "No change, recheck 1 wk." On 7/25/19, the "Anticoagulant Record" documented the current dose of Coumadin "5 mg". Written across the line for 7/25/19, "NOT DONE MD AWARE N.O. (new orders)." Review of the EMR failed to evidence a nurse's note for this date related to this entry on the "Anticoagulant Record". A physician order in the	F757		

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F757	Continued From page 360 EMR dated, 7/25/19, documented, "PT/INR on 7/26/19, notify MD of results." On 7/26/19, the "Anticoagulant Record" documented the current Coumadin dose of "5 mg". The rest of the line was blank and there was no PT/INR documented evidencing a lack of monitoring for safe administration of Coumadin to Resident #189. There were no nurse's notes for 7/26/19. The next completed INR on 7/29/19 was documented as "2.5". The last physician note dated 7/17/19, failed to evidence any documentation related to the PT/INR or the dose of Coumadin. On 7/31/19 at 2:36 p.m., an interview was conducted with ASM (administrative staff member) #5 (Resident #189's physician at the facility). ASM #5 was asked why Coumadin is monitored. ASM #5 stated Coumadin (levels) could quickly become out of control because the medication can variably react with food and other medications. ASM #5 stated this is why the medication has to be monitored. When asked how often PT/INRs should be obtained to monitor Coumadin, ASM #5 stated that depends on the patient and other variables. When asked where staff document the monitoring of Coumadin and PT/INRs, ASM #5 stated they are documented in the Coumadin book (anticoagulant record). When asked how orders for Coumadin changes and PT/INRs are communicated, ASM #5 stated those are written in the anticoagulant record and she does not write actual orders for those. When asked who is responsible for overseeing the anticoagulant record, ASM #5 stated she was not sure but she assumed the unit managers.	F757		

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F757	Continued From page 361 On 8/6/19 at 7:53 a.m., an interview was conducted with ASM #7 (the nurse practitioner), regarding her role and responsibility regarding Coumadin monitoring. ASM #7 stated the therapeutic range, is based on the resident's diagnosis and sometimes residents are admitted from the hospital with a documented therapeutic range but if not, she determines the desired therapeutic range based on the resident's diagnoses. ASM #7 stated there is a "Coumadin book" (containing "Anticoagulant Records") on each unit in the facility and the books are checked each day Monday through Friday. ASM #7 stated she and the physician rotates units they visit in the facility. ASM #7 stated that each day, she visits a unit she checks the Coumadin book. ASM #7 stated anticoagulant records, are organized in the Coumadin book based on the day of the week, so if she visits on a Tuesday, she checks the tabbed section of anticoagulant records for Tuesday. ASM #7 stated she reviews the anticoagulant records in that day's tabbed section and reviews if the INR is done or she asks the INR to be done. ASM #7 was asked what happens if changes need to be made based on the current INR. ASM #7 stated she writes the directive for the needed changes in the "Action Taken By Physician" column on the anticoagulant record, and then the nurse is supposed to check the record and write the orders for the needed changes. ASM #7 stated at times, she gives verbal directives then the nurses document the directives on the anticoagulant record. ASM #7 was asked if the directives written in the "Action Taken By Physician" column on the anticoagulant records have the full weight of a physician's order. ASM #7 stated, "Yes." ASM #7 was asked if nurses are expected to take the information documented in the "Action Taken By	F757		

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F757	Continued From page 362 Physician" column and enter that information onto a physician's order written into the computer system. ASM #7 the nurses take that information and enter orders into the computer system for medication changes but as far as how the orders are entered into the system would be a question to ask the assistant director of nursing. ASM #7 was asked if she signs off on the directives the nurses write on the anticoagulant records. ASM #7 stated she does not sign the directives but she thought most of the time, the nurses take the directives and enter them as orders into the computer system. ASM #7 stated if the directives are entered into the computer system, then they will be entered as orders under her name and the orders will display for her to sign. When asked if nurses should follow the directives in the anticoagulant records, ASM #7 stated, "Yes." ASM #7 was asked if a change in Coumadin dose should be initiated the same day the directive is written. ASM #7 stated, "Yes." ASM #7 was asked if directives for the next due PT/INR documented in the anticoagulant records should be followed. ASM #7 stated, 'Yes." ASM #7 stated she did not know if PT/INR directives documented on the anticoagulant records are entered into the computer system as actual orders or if the nurses use the directives in the anticoagulant record as written orders. On 8/6/19 at 11:23 a.m., an interview was conducted with ASM #3 (the director of nursing), regarding her role in Coumadin monitoring. ASM #3 stated the anticoagulant records were supposed to, be reviewed during daily clinical operations meetings but that had not been "getting" done so now the records will be reviewed daily at the meetings to ensure orders	F757		

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F757	Continued From page 363 for PT/INRs and Coumadin are written, transcribed and done. An interview was conducted with RN (registered nurse) #8, the assistant director of nursing, on 8/6/19 at 3:12 p.m. The "Anticoagulant Record" for Resident #189 was reviewed with RN #8. When asked about the PT/INRs that were not completed, RN #8 stated, they should be done as ordered and if not done the physician should be notified and then we follow any order that they may give. When asked if the nurses should follow the documented physician directive or a physician order, RN #8 stated, "Yes, we should always follow the physician order." RN #8 was asked about Coumadin dose changes directed/ordered by the physician after if the PT/INR tests are obtained in the morning, RN #8 stated, "It [dose change] goes into effect before the evening dose that same day." When asked if the Coumadin dose changes should be documented on the MAR and entered to start the next day, RN #8 stated, "No, it has to start the same day. That's why we do PT/INRs in the morning so we can have the correct dosage for the evening dose of Coumadin." The "Anticoagulant Record" for Resident #189 from 7/18/18 through 7/29/19, was reviewed with RN #8 and the above documented concerns reviewed. When asked if the information/physician directives on the 'Anticoagulant Record" are a physician order, RN #8 stated, "Yes, but the nurses need to transcribe it [physician directives] into the computer." When RN #8 was asked if Coumadin is held, should there be an order in the electronic record. RN #8 sated, "Yes, there should be an order anytime the Coumadin is held." When asked what the blanks on the "Anticoagulant Record" for Resident #189 on	F757		

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F757	Continued From page 364 7/30/18 and 5/4/19 indicated, RN #8 stated, "If it's blank then the doctor wasn't notified. When asked if the doctor should be notified, RN #8 stated, "Yes." RN #8 was asked what the columns on the "Anticoagulant Record" titled, Test strip lot # and Quality Control Test: Successful QCC or Error notes, meant. RN #8 stated, "Every time the nurse does the test she has to document the test strip lot number and document that the quality control gives them a check mark, even if it gives an error, then they document under the error column." When asked if this should be left blank, RN #8 stated, "No, you have to do and document that information each time a test is run." RN #8 was asked if the directive or physician order documents the Coumadin is to be on hold, and the nurse gives it, RN #8 stated it shouldn't be given if the doctor says it's to be held. When asked if the PT/INR is not completed per the physician order and/or directive, what should be done, RN #8 stated if the test is not done for any reason, the doctor must be notified that it wasn't done and to follow their orders. ASM #1, the administrator, ASM #2, the regional clinical coordinator, and ASM #3, the director of nursing were made aware of all of the above concerns on 8/6/19 at 5:19 p.m. No further information was provided prior to exit. (1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 55. (2) This information was obtained from the following website: https://vsearch.nlm.nih.gov/vivisimo/cgi-bin/query-meta?v%3Aproject=medlineplus&v%	F757		

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F757	Continued From page 365 3Asources=medlineplus-bundle&query=coumadin. (3) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 450. (4) This information was obtained from the following website: This information was obtained from the website: https://vsearch.nlm.nih.gov/vivisimo/cgi-bin/query-meta?v%3aproject=medlineplus&v%3asources=medlineplus-bundle&query=laboratory%20tests%20for%20PT%20calculation%20of%20INR&4) 6. The facility staff and physician failed to identify parameters (therapeutic goal) for Resident #129's PT [prothrombin time (3)]/INR [international normalized ratio (4)] laboratory tests to monitor and ensure the safe administration of Coumadin a high-risk anticoagulant medication. The facility staff and physician failed to obtain PT/INR tests from date of admission 6/25/19 until 7/3/19 to ensure monitoring of Resident #129's INR for the safe administration of Coumadin (5). Staff failed to transcribe directives to hold Coumadin on 7/8/19 and 7/9/19 from the anticoagulant log into physician orders in the EMR (electronic medical record), and administered Coumadin 4 mg (milligram) to the resident on 7/8 and 7/9/19. The staff also failed to initiate the Coumadin log (a paper record) which is maintained in a binder separate from the EMR for Resident #129 until 7/3/19 approximately nine days after admission. Resident #129 was admitted to the facility on 6/25/19, diagnoses that included but are not limited to: acute embolism, [a clot that travels from the site where it formed to another location	F757		

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F757	Continued From page 366 new location and block the flow of blood there] (1) and thrombosis of unspecified deep veins of right lower extremity [a blood clot that forms in a vein deep in the body] (2), fracture of one rib, diabetes and hypertension. The MDS (minimum data set) assessment, a 14 day Medicare Payment assessment, with an ARD (assessment reference date) of 7/9/19, coded the resident as scoring a 6 out of 15 on the BIMS (brief interview for mental status) score, indicating severe cognitive impairment. In Section N- Medications, the resident was coded as receiving an anticoagulant for the seven days of the look back period. The comprehensive care plan dated 7/10/19, documented in part, "Need": (Resident #129) "is at risk for abnormal bleeding/bruising related to anticoagulant use Administer medications as ordered. Observe for ineffectiveness and side effects, report abnormal findings to the physician." A review of the hospital discharge summary dated 6/25/19 at 2:54 pm, documented in part; "Discharge medications: Coumadin 5 mg oral daily. Check INR Thursday or Friday, dose as necessary." A review of the calendar indicates that 6/25/19 was a Tuesday, 6/27/19 was a Thursday, and 6/28/19 was a Friday. A review of the clinical record documented the first order to obtain a PT INR was on 7/3/19, indicating there was no monitoring of Resident #129 for the administration of Coumadin until that date. A physicians order documented on the POS (physicians order sheet) for June 2019, documented, "Order Date: 6/25/19, 18:29 (6:29 P.M.) Communication Method: Phone, Order Summary: Coumadin Tablet 5MG (milligram)	F757		

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F757	Continued From page 367 (Warfarin Sodium) Give 1 tablet by mouth in the evening related to ACUTE EMBOLISM AND THROMBOSIS OF UNSPECIFIED DEEP VEINS OF RIGHT LOWER EXTREMITY." The physician's note of 6/26/19 documented in part: "Complaint Right DVT (Deep Vein Thrombosis), on Coumadin with pertinent lab (laboratory tests) results from hospital 6/24/19 & 6/25/19 listed". The note did not include any hospital PT/INR results for Resident #129. Further review of the clinical record failed to evidence order for PT INR laboratory tests, or documentation of an identified therapeutic range for the administration of Coumadin to Resident #129. Nurse practitioner's notes on 6/27/19, 6/28/19, 6/29/19, 6/30/19, 7/1/19, documented in part: "Right popliteal DVT (on Coumadin). Monitor closely with pertinent lab results from hospital 6/24/19 & 6/25/19 listed". The notes did not include any hospital PT/INR results for Resident #129. A nurse practitioner's note on 7/2/19 documented in part; "Right popliteal DVT (on Coumadin). Monitor closely. Pertinent lab results from hospital 6/24/19 & 6/25/19 listed". The note did not include any hospital PT/INR results for Resident #129, and there was no documentation about obtaining PT INR laboratory tests or a therapeutic range for the administration of Coumadin to Resident #129. On 7/3/19, a "Anticoagulant Record" maintained separate from the clinical record for Resident #129, was started, (nine days after the resident was admitted) and documented in part; "7/3/19 Current Anticoagulant Drug Dose: Coumadin 5	F757		

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F757	Continued From page 368 mg with results PT 58.2 INR 4.8; action taken by physician Stop x 2 days, recheck 7/5/19". Review of the electronic health record revealed a documented order to obtain the PT/INR test on 7/3/19. Nurse practitioner's notes dated 7/3/19 and 7/4/19 documented in part; "Right popliteal DVT (on Coumadin). Monitor closely. Pertinent lab results from hospital 6/24/19 & 6/25/19 listed." The notes did not list any hospital PT INR results for Resident #129 and failed to document the above PT/INR result obtained on 7/3/19 at the facility. The 7/3/19 NP note did not document any action plan to stop [Coumadin] x 2 days, and to recheck 7/5/19 as documented on the anticoagulant log above for this date. On 7/5/19 Resident #129's "Anticoagulant Record" documented in part; "Current Anticoagulant Drug Dose: On hold, with results PT 39.3 INR 3.3; action taken by physician Take 4 mg (milligrams) qd (every day) and recheck on Mon. (Monday [7/8/19])." There were physician orders transcribed into the electronic health record for the PT/INR laboratory test obtained on 7/5/19 and orders to decrease Resident #129's Coumadin to 4 mg on 7/5/19. The "Anticoagulant Record" documented in part; "7/8/19 Current Anticoagulant Drug Dose: Coumadin 4 mg with results PT 62.3 INR 5.2; action taken by physician hold x 2 days, recheck 7/10/19". There were physician orders in the electronic health record for the PT/INR laboratory test obtained on 7/8/19. The nurse practitioner's note on 7/8/19, documented in part "Right popliteal DVT (on Coumadin) 4mg QD-INR elevated today. Hold x	F757		

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F757	Continued From page 369 2 and recheck 7/10/19. No s/s of bleeding. Monitor closely". There were no orders transcribed into the electronic medical record to hold Resident #129's Coumadin for two days (7/8/19 and 7/9/19) as directed in the NP note above and on the anticoagulant record. A nurse practitioner's note on 7/9/19, documented in part, "Right popliteal DVT (on Coumadin) 4mg QD-held yesterday and today for elevated INR. recheck 7/10/19. No s/s of bleeding. Monitor closely". [Note the nurse practitioner documented that Coumadin was held on 7/8 and 7/9/19 when the MAR below documented the staff had administered Coumadin 4 mg to Resident #129 on these dates. In addition, there was an order transcribed to the electronic medical record to obtain a PT/INR test on 7/10/19.] Review of the July 2019 MAR (medication administration record) for Resident #129 documented, "Coumadin Tablet 4 MG (warfarin Sodium) give 4 mg by mouth in the evening. The MAR further documented staff failed to hold the Coumadin on 7/8/19 and 7/9/19, per the physician's directive on the anticoagulant log and administered Coumadin 4 mg to the resident. The "Anticoagulant Record" documented in part; "7/10/19 Coumadin 4 mg with results PT 58.7 INR 4.9; action taken by physician hold x 2 days, recheck 7/12/19". An interview was conducted with LPN #1, the LPN for Resident #129, on 8/7/19 at 9:53 am. When asked about the process to monitor anticoagulation on newly admitted residents,	F757		

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F757	Continued From page 370 LPN #1 stated, "I make a flow sheet for them to know their baseline and get a physician order to get PT/INR the next day". When asked if this is the policy and procedure for monitoring anticoagulation, LPN #1 stated, "No each person may have their own way. I'm saying what I do." When asked about the process followed for transcribing what is written on the log sheets into orders in the electronic medical record, LPN #1 stated, "I go to the book, take what is written, and enter it into the computer. I write myself a note so if I'm not near the logbook when the physician comes, I can provide them with the information. The above lack of orders transcribed into the electronic medical record to hold Resident #129's Coumadin for two days (7/8/19 and 7/9/19) as directed in the NP note above and on the anticoagulant record was reviewed and confirmed with LPN #1. LPN #1 stated we are now doing both the book and the EMR (electronic medical record) for documentation of results and all orders". When asked when INR parameters (therapeutic range goal) was started for Resident # 129's PT/INR tests, LPN #1 stated "Monday August 5th". An interview was conducted with Administrative Staff Member ASM #6, Nurse Practitioner, on 8/1/19 at 2:47 pm. When asked about the process for ordering PT INR laboratory monitoring for Coumadin, ASM # 6 stated, "It depends if I have Point Care Click (PCC) open. If I do, I can put an order in and confirm. If not in PCC, I call and give a verbal order." When asked the time frame for ordering a PT INR for newly admitted resident, ASM # 6 stated, "I would order within a couple of days of admission." An interview was conducted with ASM #7, Nurse Practitioner, on 8/6/19 at 7:53 am. When asked	F757		

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F757	Continued From page 371 about her role and responsibilities for ordering PT INR tests, ASM # 7 stated, "If I reviewed the orders, I would ask for the INR on admission and based on that result decide order for medication and lab [laboratory test]". When asked if what she writes on the "Anticoagulant Record" for changes in Coumadin doses or PT INR tests, are considered an order, ASM #7 stated "Yes, I consider that an order". ASM # 7 stated, "It is my understanding that the nurses transcribe what is written on the log sheets and enter those changes into the computer". When asked about identifying INR parameters for administering Coumadin, ASM # 7 stated, "Sometimes the hospital is still getting the therapeutic range. Therapeutic range depends on the resident's diagnosis. Usually [PT/INR] 2-3". An interview was conducted with ASM #5, Physician, on 8/7/19 at 9:30 am. When asked about the time frame for ordering PT INR monitoring for a newly admitted resident receiving Coumadin, ASM # 5 stated, "If the hospital sets a date for recheck, we follow that. My preference is in a couple of days after admission. If I reviewed the orders, I would ask for the INR on admission and based on that result decide the order for medication and lab". When asked about identifying INR parameters for administering and monitoring the administration of Coumadin, ASM # 5 stated, "Therapeutic range depends on the resident's diagnosis. Usually [PT/INR] 2-3". When asked how PT INR results are entered into progress notes, ASM # 5 stated, "The note is not accurate as the information is not available. I can't see the results in the EMR (electronic medical record), I can only see them if I'm sitting right next to the Coumadin book."	F757		

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F757	Continued From page 372 On 8-5-19 at 2:33 p.m. an interview was conducted with administrative staff member (ASM) #3, Director of Nursing. When asked how staff ensure ensure a care plan is implemented for Coumadin, ASM #3 stated, "We review them in the clinical ops meeting". When asked if this was the process prior to the concerns identified on this survey, ASM #3 stated, "No, we didn't' look at the entire process including Coumadin logs." When asked if PT /INR orders were part of the review process, ASM #3 stated "Now they are included in the review". On 8/6/19 at 10:18 a.m. administrative staff member (ASM) #2, the regional clinical coordinator, was asked what standard of practice the facility follows for the monitoring of anticoagulants, ASM #2 stated, "We follow our policies and Lippincott". According to Lippincott Manual of Nursing Practice-"Coumadin: Maintaining Clotting Profiles: Prothrombin time (PT) and international normalized ratio (INR) are the coagulation tests used to monitor the anticoagulation effects of Coumadin. Note: the desired levels of the INR are determined by the health care provider. Obtain PT/INR levels daily or as ordered. Coumadin dose will be adjusted to achieve the desired level of anticoagulation. Preventing Bleeding: Have on hand the antidotes to reverse anticoagulants being used: Warfarin-phytonadione (vitamin K, AquaMEPHYTON). Patient Education and Health Maintenance: Instruct patient about taking anticoagulants. Follow instructions carefully and take medications exactly as prescribed; if a dose is missed, do NOT double up dose". (6) Administrative staff members (ASM) # 1, the	F757		

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F757	Continued From page 373 administrator, (ASM) # 2, the regional clinical coordinator and (ASM) #3 the director of nursing, were made aware of the above concerns on 8/7/19 at 3:15 pm No further information was provided prior to exit. 1. This information was retrieved from the following website: https://medlineplus.gov/ency/imagepages/18076.htm 2. This information was retrieved from the following website: https://medlineplus.gov/deepveinthrombosis.html 3. This information was retrieved from the following website: https://labtestsonline.org/tests/prothrombin-time-and-international-normalized-ratio-ptinr# 4. This information was retrieved from the following website: https://labtestsonline.org/tests/prothrombin-time-and-international-normalized-ratio-ptinr# 5. Nursing 2016 Drug Handbook (Wolters Kluwer, 2016, p.1495) Black Box Warning 6. Lippincott Manual of Nursing Practice (Lippincott, Williams & Wilkins, 8th edition, page 432). 7. The facility staff failed to ensure Resident #601, received adequate monitoring for the anticoagulant (blood thinning medication) medication Coumadin, to ensure appropriate administration of the high-risk medication. The facility staff failed to identify INR parameters (therapeutic goal) for monitoring and the safe administration of Coumadin (4) to Resident # 601. Staff failed to evidence a PT(3)/INR(4) test was obtained as ordered on 7/26/19.	F757		

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	495109	A. BUILDING _____ B. WING _____	C 08/07/2019

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F757	Continued From page 374 Resident #601 was admitted to the facility on 7/23/19 with diagnoses that include but are not limited to: acute embolism (1), and thrombosis of unspecified deep veins of right lower extremity (2), weakness and altered mental status. The most recently submitted MDS (minimum data set) assessment, was an admission tracking assessment dated 7/23/19. The MDS was not completed as of survey 7/30/19. The nurse practitioner's note of 7/25/19 at 9:55 a.m. documented "Discharged from (name of hospital) on 7/23/19. Psychiatry has deemed that patient has limited decision-making capacity. Dementia behavior has stabilized... ". Resident #601 was not observed due to admission to acute care facility on 8/4/19. The baseline care plan dated 7/23/19, documented in part, "Anticoagulant": (Resident #601) "Goal documented in part- no signs/symptoms of action bleeding", with "Interventions documented in part- labs [laboratory tests] as ordered; observe for signs/symptoms of bleeding, report as indicated; protect from injury." The comprehensive care plan initiated 8/1/19, documented in part, "Resident # 601 at risk for abnormal bleeding, bruising related to anticoagulant use". A physician's order documented on the POS (Physician order sheet) for July 2019, documented, "Order Date: 7/23/19, 23:50 (11:50 P.M.) Communication Method: Phone, Order Summary: Coumadin Tablet 7.5 MG (milligram) (Warfarin Sodium) Give 7.5 mg by mouth in the evening every Mon, Wed, Thu, Fri, Sun for A-fib [atrial fibrillation]".	F757		

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F757	Continued From page 375 A nurse practitioner's note dated 7/25/19, documented in part: "Of note, patient on warfarin for history of left ventricular thrombus. INR was therapeutic on day of discharge 7/23/19 at 2.4. Ordered warfarin 5mg daily, ordered INR 7/26, if INR at goal will order INR 2/week on Mon/Thur". The note did not include identified INR parameters (therapeutic goal) for monitoring, to ensure safe administration of Coumadin to Resident #601. A physician's order documented on the POS for July 2019, documented, "Order Date: 7/26/19, 9:00 A.M. Communication Method: Computer, Order Summary: PT/INR one time only for LV (left ventricular) thrombus". "Order Date: 7/26/19, 9:00 A.M. Communication Method: Computer, Order Summary: Warfarin Sodium Tablet 5 mg by mouth in the evening for LV thrombus". A nurse progress note of 7/26/19 11:12 pm, documented in part: "PT INR one time for LV (left ventricular) thrombus for 1 day, call result to NP. This order was put in for 9:00am not sure if was obtained". The nurse practitioner's note of 7/29/19, documented in part: "Patient fell 7/26 PM while transferring wheel chair to toilet; hit head, no loss of consciousness, complaint headache and nursing staff gave Tylenol; on call doctor given INR result of 2.2; no dose change. INR 7/26 was 2.2; continue warfarin 5mg daily; ordered INR 8/1/19". [Note: The PT/INR referenced in this note was not located in the EMR. The record failed evidence the 7/26/19 INR results, were obtained. There were no documented results located under the laboratory results tab in the EMR (electronic medical record), or nurses notes. The anticoagulant record was not	F757		

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F757	Continued From page 376 initiated until 8/1/19 as documented below.] An "Anticoagulant record" for Resident #601 was not initiated until 8/1/19 and documented in part; 8/1/19 Coumadin 5mg with results PT 16.4 INR 1.5; action taken by physician Coumadin 5.5 mg, recheck 8/5/19. A review of the clinical record showed that the 8/1/19 order had been transcribed to the EMR and MAR and the order was initiated and it was documented as given on MAR. An interview was conducted with LPN #1, the LPN for Resident #129, on 8/7/19 9:53 am. When asked about the process to monitor anticoagulation on newly admitted residents, LPN #1 stated, "I make a flow sheet [anticoagulant record] for them to know their baseline and get a physician order to get PT/INR the next day". When asked if this is the policy and procedure for monitoring anticoagulation, LPN #1 stated, "No each person may have their own way. I'm saying what I do". LPN #1 was asked about the process to transcribe directives on the log sheets [anticoagulant record] into orders in the EMR and onto the MAR (medication administration record). LPN #1 stated, "I go to the book, take what is written, and enter it into the computer. I write myself a note so if I'm not near the logbook when the physician comes, I can provide them with the information. Now we are doing both the book and the EMR (electronic medical record) for documentation of results and all orders". When asked about Resident 601 not having identified INR parameters for the administration of Coumadin, LPN #1 stated, now we have a therapeutic range of 2-3.5." When asked when a therapeutic range was started, LPN #1 stated "Monday August 5th".	F757		

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F757	Continued From page 377 An interview was conducted with ASM #7, Nurse Practitioner, on 8/6/19 at 7:53 am. When asked about her role and responsibilities for ordering PT INR tests, ASM # 7 stated, "If I reviewed the orders, I would ask for the INR on admission and based on that result decide order for medication and lab [laboratory test]". When asked about identifying INR parameters for administering and monitoring Coumadin, ASM # 7 stated, "Sometimes the hospital is still getting the therapeutic range. Therapeutic range depends on the resident's diagnosis. Usually [PT/INR] 2-3". An interview was conducted with ASM #5, Physician, on 8/7/19 at 9:30 am. When asked about INR parameters or goals for administering Coumadin, ASM # 5 stated, "Therapeutic range depends on the resident's diagnosis. Usually [PT/INR] 2-3". When asked how PT INR results are entered into progress notes, ASM # 5 stated, "The note is not accurate as the information is not available. I can't see the results in the EMR (electronic medical record), I can only see them if I'm sitting right next to the Coumadin book." On 8/6/19 at 10:18 a.m. administrative staff member (ASM) #2, the regional clinical coordinator, was asked what standard of practice the facility follows for the monitoring of anticoagulants, ASM #2 stated, "We follow our policies and Lippincott. Administrative staff members (ASM) # 1, the administrator, (ASM) # 2, the regional clinical coordinator and (ASM) #3 the director of nursing, were made aware of the above concerns on 8/7/19 at 3:15 pm No further information was provided prior to exit.	F757		

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F757	Continued From page 378 1. This information was retrieved from the following website: https://medlineplus.gov/ency/imagepages/18076.htm 2. This information was retrieved from the following website: https://medlineplus.gov/deepveinthrombosis.html 3. This information was retrieved from the following website: https://labtestsonline.org/tests/prothrombin-time-and-international-normalized-ratio-ptinr# 4. This information was retrieved from the following website: https://labtestsonline.org/tests/prothrombin-time-and-international-normalized-ratio-ptinr# 5. Nursing 2016 Drug Handbook (Wolters Kluwer, 2016, p.1495) Black Box Warning 8. The facility staff failed to ensure Resident #8, received adequate monitoring for the anticoagulant (blood thinning medication) medication Coumadin, (1) to ensure appropriate administration of the high-risk medication. On 11/10/18 and 05/10/19, PT [prothrombin time] (2)/INR [International ratio] (3) tests were not obtained per the documented recommendations in the Nurse practitioner notes and on the facility's anticoagulant record. In addition, staff failed to ensure the resident did not receive unnecessary medications. On 8/21/18, staff administered 15.5 mg of Coumadin instead of the 8 mg ordered. On 5/2/19 instead of holding the Coumadin, as ordered, staff administered 6 mg (milligram) of Coumadin to the resident and continued to administer the wrong dose for 12 days through 5/14/19. The staff also failed to transcribe the physician's directives for PT/INR monitoring from the anticoagulant record to Resident # 8's EHR (electronic health record) on	F757		

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F757	Continued From page 379 multiple dates during June, July August 2018, January February, March, May and June 2019. "Black box Warning: WARNING: BLEEDING RISK: COUMADIN can cause major or fatal bleeding. Bleeding is more likely to occur within the first month. Risk factors for bleeding include high intensity of anticoagulation (INR >4.0), age greater than or equal to 65, history of highly variable INRs [international ration ...." "Perform regular monitoring of INR in all treated patients. Those at high risk of bleeding may benefit from more frequent INR monitoring careful dose adjustment to desired INR, and a shortest duration of therapy appropriate for the clinical condition. However, maintenance of INR in the therapeutic range does not eliminate the risk of bleeding." This information was obtained from the website: https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=d91934a0-902e-c26c-23ca-d5accc4151b6 Resident # 8 was admitted to the facility on 08/14/2015 and a readmission on 01/08/2019 with diagnoses that included but were not limited to: deep vein thrombosis (1), other specified disorders of veins and high cholesterol. Resident # 8's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 04/19/19, coded Resident # 8 as scoring a seven on the brief interview for mental status (BIMS) of a score of 0 - 15, seven - being severely impaired of cognition for making daily decisions. Section N "Medications" coded Resident # 8 as receiving an anticoagulant (2) in the past seven days. The comprehensive care plan for Resident # 8	F757		

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F757	Continued From page 380 (Resident # 8) is at risk for abnormal bleeding/bruising R/T (related to): medication use. Anticoagulant. Hx (history) of GI (gastrointestinal) bleeding." Under "Interventions", it documented in part, "Administer medications as ordered. Observe for effectiveness and side effects, report abnormal findings to the physician. Date initiated: 02/05/2019, Obtain labs (laboratory tests) and diagnostics as ordered and report abnormal findings to the physician. Date initiated 02/05/2019." A nurse practitioner's note dated 06/28/1018 documented, "HPI (history of present illness): Male patient on Coumadin (1) for DVT. INR (international normalized ratio) 2.2. He is currently taking Coumadin 6.5mg (milligrams) daily. No s/sx (signs or symptoms) of bleeding. A/P (Assess/Plan): Leg DVT (deep vein thrombosis) (4) - Stable. INR 2.2. Goal: 2-3 (two to three)." The MAR for June 2018 documented give 6.5 mg of Coumadin with a start date of 6/22/18. Review of the MAR revealed the Coumadin was administered as ordered. On 8/20/18, Resident #8's "Anticoagulant Record" documented, "Current Anticoagulant Drug and Dose: Coumadin 7.5mg." "PT: 16.7. INR: 1.4 [below the documented goal of 2-3]" "08/20/18 Action Taken by Physician: arrow pointing up (increase Coumadin) 8mg qd (every day) recheck in 1 wk (week)." A physician's telephone order dated 08/20/18 at 11:58 a.m. for Resident # 8 documented, "Order Summary: Warfarin Sodium Tablet Give 8mg by mouth every evening shift for treating/preventing blood."	F757		

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F757	Continued From page 381 The eMAR (electronic medication administration record) dated August 2018 documented the physician's telephone order dated 08/20/18 as stated above. Further review of the eMAR revealed a check mark and the nurse's initials under the date of 08/21/18 indicating Resident # 8 received 8 mg and 7.5 mg of Coumadin on 08/21/18. The "Anticoagulant Record" for Resident # 8 dated 08/27/18 documented, "PT: 429. INR: 3.6 [above the documented goal of 2-3 placing the resident at risk for bleeding]." Review of the nurse's progress notes, physician notes and nurse practitioner notes dated 08/01/18 through 08/31/18 failed to evidence any documented recommendations or orders for the resident to receive both 8 mg and 7.5 mg for a total of 15.5mg of Coumadin on 08/21/18. On 8/23/18, a physicians order to discontinue Coumadin 7.5 mg was obtained from the physician and documented: "Order Summary: Coumadin Tablet 7.5 MG (Warfarin Sodium) Give 1 (one) tablet by mouth in the evening for anticoagulant therapy. Discontinue Date / Reason: increase in dosage." The facility's "Nurse Practitioner's Note" for Resident # 8 dated 11/09/18, signed by ASM (administrative staff member) # 7, nurse practitioner, at 12:45 p.m. documented in part, "HPI (History of Present Illness): ATSP (Asked To See Patient) for lab (laboratory) review. Male patient on Coumadin for DVT. INR: 3.5. Goal 2-3 (two to three). On 6 (six) mg daily. No s/sx of bleeding." Under "A/P (Assessment/Plan)" it documented, "Leg DVT - Stable. INR elevated. Hold Coumadin x1 (times one day) and recheck tomorrow." The Physician's telephone order documented,	F757		

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F757	Continued From page 382 "Created Date: 11/9/18 at 17:14 (5:14 p.m.) Communication method: Phone." Documented "Order Summary: Coumadin Tablet 6 MG [milligram] (Warfin Sodium) Give 6 MG by mouth in the evening for anticoagulant therapy Discontinue 11/9/18 17:14 (5:14 p.m.) Discontinue Date/Reason: on hold Confirmed By: name of (Licensed Practical Nurse)." A second physicians order date 11/9/2018 at 17:15 (5:15 p.m.) documented, "Order Summary: check pt/inr on sat [Saturday] 11/10/18 one time only for coumadin use 1 day." The facility's "Anticoagulant Record" for Resident # 8 dated 11/09/18 documented, Current Anticoagulant Drug and Dose: "Coumadin 6 mg (milligrams)" "PT 3.5 INR: 41.6 [Note the staff entered the INR level under PT and the PT level under the INR. The INR was elevated above the resident goal placing the resident at risk for bleeding]." Under "Action Taken by Physician" it documented, "Hold x 1 (times one day) re-check 11/10/18." Further review of the "Anticoagulant Record" failed to evidence results of a PT/INR for 11/10/18 and evidence and the facility system for monitoring for safe administration of Coumadin was ineffective. A Nurse's Note" dated 11/09/18 for Resident # 8 at 7:25 p.m. documented, "Hold Coumadin 6MG (milligrams) today 11/09/18 recheck PT/INR on SAT (Saturday) 11/10/18 will cont (continue) to monitor guest." Further review failed to evidence nurses notes documenting why the PT INR was not obtained on 11/10/18 as ordered by the physician. A "Nurse Practitioner's Note" for Resident # 8 dated 05/01/19, signed by ASM (administrative staff member) # 7, nurse practitioner, at 12:26 p.	F757		

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F757	Continued From page 383 m. documented in part, "HPI (history of present illness) INR: 5.1. Under "A/P" it documented, "Leg DVT - Stable. INR elevated. Hold Coumadin x1 (times one day) and recheck on 5/2/19. Monitor closely." A physicians order dated 5/1/19 documented, "Order Summary: PT/INR 5/01/19 one time only for anticoagulation therapy for 1 day. A physician's telephone order dated 05/01/19 for Resident # 8 documented, "Coumadin Tablet 6MG (Warfarin Sodium). Give 6MG by mouth one time a day for anti-coagulant. Hold 05/01/2019 14:45 (2:45 p.m.) - 05/02/2019 14:44 (2:44 p.m.)." The facility's "Anticoagulant Record" for Resident # 8 dated 05/01/19 documented, "Current Anticoagulant Drug Dose Coumadin 6 mg PT 61.5 INR: 5.1 [higher than the goal of 2-3 placing the resident at risk for bleeding]." Under "Action Taken by Physician" it documented, "Hold x 1 (times one day) re-check 5/2/19." On 5/2/19 the "Anticoagulant Record" for Resident # 8 dated 05/01/19 documented, "Current Anticoagulant Drug Dose: Held on 5/1/19, PT 36.9 INR 3.1" Under "Action Taken by Physician" it documented, "Hold x 1 (times one day) re-check 5/3/19." The nurse's progress note for Resident # 8 dated 05/02/2019 at 4:44 p.m. documented in part, "PT/INR 39.0/3.2. Per MD (medical doctor), hold Coumadin today and recheck tomorrow." A "Nurse Practitioner's Note" for Resident # 8 dated 5/03/19, signed by ASM (administrative staff member) # 7, nurse practitioner, at 5:10 p.	F757		

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F757	Continued From page 384 m. documented in part, "A/P: Leg DVT - Stable. 5MG coumadin QD (every day) and check INR 5/10/19. Monitor closely." On 5/3/19 Resident #8's "Anticoagulant Record" documented, "Current Anticoagulant Drug Dose: Coumadin 6 mg held on 5/2/19, PT 24.9 INR 2.1" Under "Action Taken by Physician" it documented, " 5 mg QD [every day] re-check 5/10/19." Further review of the "Anticoagulant Record" failed to evidence results of a PT/INR for 05/10/19. The Date 5/10/19 was crossed out with a line on the Anticoagulant Record. A hand written notation was written beside the crossed out date 5/10/10, documented, "MD (medical doctor) aware NNO (no new order)." Review of the May 2019 eMAR revealed, "Coumadin Tablet 6 MG (Warfarin Sodium) Give 6 mg by mouth one time a day for anti-coagulant. Start Date- 01/11/2019 1700 (5:00 p.m.), -Hold Date- from 05/01/2019 1445 (4:45 p.m.) -05/02/2019 1444 (2:44 p.m.). This order was documented as discontinued on 5/15/19. Review of the eMAR for 5/2/19 evidenced staff initials with a check mark on 5/2/19 indicating Resident #8 was administered 6 mg of Coumadin instead of holding the medication as ordered. Further review of the MAR revealed Resident #8 received 6 mg of Coumadin at 1700 (5:00 p.m.) every day from 5/2 through 5/14/19 instead of the 5mg of Coumadin ordered for a total of 12 days. On 5/15/19, the MAR documented a"5" for the dose of Coumadin 6mg. Per the eMAR a 5 indicates hold see nurses notes. Review of the EHR (electronic health record) failed to evidence a physician's order was transcribed for the reduction of Resident # 8's Coumadin to 5mg as directed on the	F757		

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F757	Continued From page 385 anticoagulant record. On 8/1/19 at approximately 2:59 p.m., an interview was conducted with LPN # 3 (licensed practical nurse), regarding the lack of PT/INR results on Resident #8's anticoagulant log on 5/10/19. LPN # 3 was asked what it meant if the laboratory [lab] results weren't written on the log. LPN # 3 stated, "It means that the lab wasn't drawn." LPN # 3 also stated that the physician was aware the PT/INR had not been drawn. LPN # 3 was asked if she knew why the PT/INR had not been drawn for Resident #8. LPN # 3 stated, "I'm unsure." Further review of Resident #8's clinical record revealed no additional documentation as to why the PT/INR was not drawn. Review of the clinical record failed to reveal a nurse's note dated 5/15/19. A nurses note dated 5/14/19 documented, "n.o. (new order) PT INR 5/15/19. On 5/15/19 Resident #8's "Anticoagulant Record" documented, PT 18.0 INR 1.5. "Under "Action Taken by Physician" it documented, "arrow pointing up (increase) Coumadin to 6.5 mg recheck 5/22/19." Under "Quality Control Test", the column for "Successful QC (quality control)" and "Error Noted" were blank. There was nothing documented evidencing the staff had completed the check to ensure the code on the strips matched the code the CoaguCheck XS machine used to obtain the PT/INR tests to ensure results obtained were accurate. On 7/31/19 at 2:36 p.m., an interview was conducted with ASM (administrative staff member) #5, Resident # 8's physician at the facility. ASM #5 was asked why Coumadin must be monitored. ASM #5 stated Coumadin (levels)	F757		

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F757	Continued From page 386 could quickly become out of control because the medication can variably react with food and other medications. ASM #5 stated this is why the medication has to be monitored. ASM #5 was made aware there was missing evidence of Coumadin monitoring in Resident # 8's clinical record and the Coumadin was not held on 05/02/19. ASM #5 reviewed her notes and stated she had no documentation in her notes. On 8/1/19 at 8:46 a.m., an interview was conducted with RN (registered nurse) #1, regarding the facility process for Coumadin monitoring. When asked if actual physician's orders are written for PT/INR tests and Coumadin dose changes, RN #1 stated she would put an order into the computer for a Coumadin dose change but she thought orders for PT/INRs are not written and are only documented in the anticoagulant record. On 8/5/19 at 3:44 p.m., an interview was conducted with RN (registered nurse) #8 (assistant director of nursing). RN #8 was asked if physician's orders regarding Coumadin and PT/INRs should be written. RN #8 stated physician's orders to hold Coumadin, change a dose of Coumadin, and for the next PT/INR that is due should be written. When asked about the facility process for ensuring the orders are written, RN #8 stated the anticoagulant records should be reviewed each morning. The facility's "Anticoagulant Record" for Resident # 8, documented, PT/INR checks under the heading of "Action Taken By Physician" on the following dates from June 2018 through June 2019. The dates are as follows: 06/28/18, 07/05/18, 07/13/18, 08/20/18, 08/2718, 08/30/18, 01/11/19, 01/31/19, 02/04/19, 03/25/19, 05/01/19, 05/02/19,	F757		

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F757	Continued From page 387 05/03/19 and on 06/25/19. Review of the physician order sheets and physician's telephone orders dated 06/28/18 through 06/25/19 failed to evidence the physician's directives from Resident # 8's anticoagulant record were transcribed to physician's orders for the dates listed above. On 08/06/19 at 11:15 a.m., another interview was conducted with RN (registered nurse) # 8, assistant director of nursing/unit manager regarding the incorrect doses and the double dose of Coumadin Resident # 8 received on 8/21/18 and 05/03/19 through 05/14/19. RN #8 reviewed Resident #8's anticoagulant record, eMAR dated August 2018 and May 2019 and the progress notes. RN # 8 stated, "He should have only received 8mg" referring to 08/21/18 and confirmed that Resident # 8 was not receiving the correct dose from 05/03/19 through 05/14/19. When asked what would happen if a resident received too much Coumadin, RN # 8 stated the resident's blood could become too thin and they could bleed. RN #8 was asked about Resident #8's Coumadin not being held as ordered on 05/02/10. RN # 8 stated the order should have been followed to hold it. RN #8 was asked the transcription of the physician's directive from the anticoagulant record to Resident # 8's EHR (electronic health record) for the dates above. RN # 8 stated, "There should be a physician's order to recheck the PT/INR. If the dose is changed, if a recheck is requested and if the medication is held there should be an order." When informed of the dates listed above, RN # 8 stated she would check progress notes. On 8/6/19 at 11:23 a.m., an interview was conducted with ASM #3 (the director of nursing), regarding her role in Coumadin monitoring.	F757		

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F757	Continued From page 388 ASM #3 stated the anticoagulant records were supposed to be reviewed during daily clinical operations meetings but that had not been "getting" done so now the records will be reviewed daily at the meetings to ensure orders for PT.INRs and Coumadin are written, transcribed and done. On 8/6/19 at 10:18 a.m. administrative staff member (ASM) #2, the regional clinical coordinator, was asked what standard of practice the facility follows for the monitoring of anticoagulants, ASM #2 stated, "We follow our policies and Lippincott". On 08/06/19 at 3:15 p.m., RN # 8 stated that she was unable to find physician's orders for the PT/INRs and that the orders were not transcribed into Resident # 8's electronic record. On 08/05/19 at 5:10 p.m., ASM (administrative staff member) #1, administrator, ASM # 2, regional clinical coordinator and ASM #3 (director of nursing) were made aware of the above concern. No further information was presented prior to exit. References: (2) PT (prothrombin): This information was obtained from the website: https://medlineplus.gov/ency/article/003652.htm. (3) International normalized ratio (INR): This information was obtained from the website: https://www.ncbi.nlm.nih.gov/books/NBK507707/ . (4) DVT (deep vein thrombosis): This	F757		

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F757	Continued From page 389 information was obtained from the website: https://medlineplus.gov/ency/article/000156.htm. 9. The facility staff failed to implement and monitor the effectiveness of non-pharmacological interventions prior to administering as needed Roxicodone (1) to Resident # 96, as ordered by the physician. Resident # 96 was admitted to the facility on 07/04/2019 with diagnoses that included but were not limited to: chronic pain and right knee pain. Resident # 96's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 07/10/19, coded Resident # 96 as scoring a 14 on the brief interview for mental status (BIMS) of a score of 0 - 15, 15 - being cognitively intact for making daily decisions. Section J "Health Conditions" coded Resident # 96 as having frequent severe pain. The POS (physician's order sheet) dated August 2019 for Resident # 96documented: "Roxicodone Tablet 5 (five) MG (milligrams) (oxyCODONE HCl (hydrochloric acid) Give 5 mg by mouth every 6 (six) hours as needed for Pain related to OTHER CHRONIC PAIN. Order Date: 05/30/2019. Start Date: 05/30/2019." "Document non-pharmacological Interventions prior to administering PRN [as needed] medication for pain. 1) Repositioning, 2) cold compress or ice pack, 3) Warm compress, 4) Massage, 5) elevation, 6) deep breathing or guided imagery as needed for pain management document intervention number. Date Ordered 07/25/2018. Start Date: 07/25/2018." The eMAR (electronic medication administration	F757		

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F757	Continued From page 390 record) for Resident # 96 dated "May 2019" documented the same orders as stated in the POS above. Review of the eMAR revealed Roxicodone 5mg was administered on "05/31/19 at 10:28 a.m." Further review failed to evidence documentation non-pharmacological interventions were implemented as ordered above on 05/31/19 at 10:28 a.m. The eMAR (electronic medication administration record) for Resident # 96 dated "June 2019" documented the same orders as stated in the POS above. Review of the eMAR revealed Roxicodone 5mg was administered on: "06/03/19 at 9:22 a.m. and 1630 (4:30 p.m.), 06/10/19 at 1721 (5:21 p.m.), 06/12/19 at 1800 (6:00 p.m.), 06/15/19 at 0145 (1:45 a.m.), 06/17/19 at 0243 (2:43 a.m.), 06/24/19 at 1419 (2:19 a.m.), and on 06/27/19 at 1800 (6:00 p.m.)." Further review failed to evidence documentation non-pharmacological interventions were implemented as ordered on the dates listed above. The eMAR (electronic medication administration record) for Resident # 96 dated "Jul (July) 2019" documented the same orders as stated in the POS above. Review of the eMAR revealed Roxicodone 5mg was administered on: "07/03/19 at 1634 (4:34 p.m.), 07/05/19 at 1302 (1:32 p.m.), 07/17/19 at 1430 (2:30 p.m.), 07/18/19 at 1700 (5:00 p.m.), 07/20/19 at 1335 (1:35 p.m.), 07/21/19 at 1506 (3:56 p.m.), 07/22/19 at 0927 (9:27 a.m.) and at 1609 (4:09 p.m.), 07/26/19 at 1336 (1:36 p.m.), 07/27/19 at 0200 (2:00 a.m.) and at 1846 (6:46 p.m.), and on 07/29/19 at 10212 (10:12 a.m.)." Further review failed to evidence documentation non-pharmacological interventions were implemented as ordered on the dates listed above.	F757		

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F757	Continued From page 391 Review of the nurse's progress notes and eMAR notes for Resident # 96 dated 05/31/19 through 07/29/19 failed to evidence documentation of non-pharmacological interventions prior to the administration of Roxicodone 5mg on the dates listed on the eMARs listed above. The comprehensive care plan for Resident # 96 dated 12/21/2018 documented, "Need. (Resident # 96) has chronic pain r/t (related to) DX (diagnosis): gerd (gastroesophageal reflux disease), seizures, ms (multiple sclerosis), htn (hypertension). Date Initiated: 12/21/2018." Under "Interventions" it documented, "Administer medications as ordered. Observe for ineffectiveness and side effects, report abnormal finding to the physician. Date Initiated: 12/21/2018." On 08/01/19 at 11:36 a.m., an interview was conducted with LPN (licensed practical nurse) # 2 regarding the procedure for administering prn (as needed) pain medication. LPN # 2 stated, "I ask the resident where the pain is, what the level is based a scale of zero to ten with ten being the worst pain, administer the medication and recheck the resident after about an hour for effectiveness." When asked if she would attempt non-pharmacological interventions prior to the administration of the pain medication to try and alleviate the pain LPN # 2 stated, "Generally yes." When asked where they document non-pharmacological interventions are tried and/or attempted LPN # 2 stated, "In the nurse's notes." After reviewing Resident # 96's eMARs, nurse's notes and eMAR notes dated 05/31/19 through 07/29/19 LPN # 2 stated, "It's not being done because it's not documented." 08/06/19 at 9:15 p.m., an interview was	F757		

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F757	Continued From page 392 conducted with Resident # 96 regarding her pain management. When asked what the nurse does prior to administering her prn pain medication Resident # 96 stated, "They ask me the level of pain, a number and where the pain is." When asked if the staff tries to alleviate her pain by attempting other measures prior to administering the pain medication, Resident # 96 stated, "No." The facility's policy "Pain Management Program" documented, "The Pain Management Program will be used by nursing staff to evaluate, provide appropriate interventions, and monitor the effectiveness of the pain regimen for guests experiencing acute and/or chronic pain, in order to promote comfort and the ability to reach their highest functional level." Under "Intervention" it is documented "1. The nurse will develop a written care plan for pain relief, considering medicinal and non-medicinal interventions. (Non-medicinal interventions should be attempted before medicinal interventions are explored.) 11. The nurse will document the effectiveness of the intervention (may use E for effective or a number value to represent the effectiveness of the intervention) and continue with the current plan or revise the plan as indicated. This should be done for analgesic and/or Non-Pharmacy interventions." On 08/05/19 at 5:10 p.m., ASM (administrative staff member) #1, administrator, ASM # 2, regional clinical coordinator and ASM #3 (director of nursing) were made aware of the above concern. No further information was presented prior to exit. References: (1) Are an immediate-release oral formulation of	F757		

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F757	Continued From page 393 oxycodone hydrochloride indicated for the management of moderate to severe pain where the use of an opioid analgesic is appropriate. This information was obtained from the website: https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=d48c22ff-bbb4-4a93-a35b-6eebff7b8e53. 10. The facility staff failed to implement and monitor the effectiveness of non-pharmacological interventions prior to administering as needed Acetaminophen (1) to Resident # 27, to determine if medication was indicated. Resident # 27 was admitted to the facility on 10/26/2017 with diagnoses that included but were not limited to: osteoarthritis (2) and breast cancer. Resident # 27's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 05/09/19, coded Resident # 27 as scoring a one on the brief interview for mental status (BIMS) of a score of 0 - 15, one - being severely impaired of cognition for making daily decisions. Section J coded Resident # 27 as being unable to answer the pain assessment interview. The staff assessment for pain documented vocal complaints of pain from Resident # 27 and showing indicators of pain or possible pain observed 3 to 4 days in the five days prior to the ARD. The POS (physician's order sheet) dated August 2019 for Resident # 27 documented, "Acetaminophen Tablet 325 (five) MG (milligrams. Give two tablets by mouth every 4 (four) hours as needed for pain/ fever greater	F757		

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