| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 195293 | A. Building<br>B. Wing | 10/25/2024 |

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| Natchitoches Nursing and Rehabilitation Center,llc | 750 Keyser Avenue<br>Natchitoches, LA 71457 |

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| F 0565<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Honor the resident's right to organize and participate in resident/family groups in the facility.<br><br>38373<br><br>Based on record review, observation, and interview, the facility failed to provide a private space for the Resident Council Meeting held 10/07/2024 and failed to act promptly upon the grievances voiced by the residents during monthly resident council meetings.<br><br>The deficient practice had the potential to affect a total of 66 residents residing in the facility.<br><br>Findings:<br><br>Review of the facility's policy titled Resident Council dated 02/2017 revealed in part .<br><br>1. The Resident Council structure and process will be established by the residents with the Social Services staff.<br><br>2. Monthly meetings will be scheduled in an area that promotes privacy or per Resident request.<br><br>Review of the facility's policy titled Complaint/Grievance/Missing Property dated 01/2015 revealed in part .<br><br>A.1. Resident Council meetings are to allow time for residents to address concerns or complaints. Minutes are to reflect the issues and the direction taken. Respective Department Heads and/or Executive Director will follow up on issues noted.<br><br>In an observation of the Resident Council meeting on 10/07/2024 at 1:30 p.m., it was noted the meeting was held in the day room near the front entrance of the facility, and near the nurses' station. The area was open to anyone who entered the front door, in view of the nurses' station, open to a resident hallway, and connected to the dining room. During the meeting, a staff member walked through and held a conversation with the social services staff who was assisting with the meeting, and two staff members were seated at the nurses' station. During the meeting, a visitor entered the facility and stood in the day room area, and listened to a portion of the meeting.<br><br>During the 10/07/2024 Resident Council meeting, residents complained about staff not rounding every two hours, call lights not being answered timely, beds not being made, and CNAs waking them up at night being too loud. The residents reported these issues had been an ongoing problem that had not been addressed by the facility.<br><br>(continued on next page) |

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

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|

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| F 0565<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Review of the Resident Council meeting held 09/11/2024 revealed in part .<br><br>Old business-was this issue resolved to your satisfaction? No, related to call lights.<br><br>New business-11 in attendance complained beds were not being made, rounds not being done by staff, and call lights were not being answered in a timely manner.<br><br>Review of the Resident Council meeting held 08/14/2024 revealed in part .<br><br>Old business-Was this issue resolved to your satisfaction? 5 residents stated no, related to beds not being made in timely manner, and 6 residents responded no, related to loud CNAs at night.<br><br>Review of the Resident Council meeting held 07/10/2024 revealed in part .<br><br>New business-8 residents complained CNAs of loud at night, 7 residents complained that more room rounds were needed, and 7 residents complained beds were not being made in a timely manner.<br><br>Review of the Resident Council binder revealed the facility responded to the above complaints by in-servicing staff monthly. No other interventions were documented.<br><br>In an interview on 10/09/2024 at 1:30 p.m., S1 Administrator and S2 DON acknowledged the Resident Council meeting was not held in a private space, and the concerns voiced by the members continued for multiple months, and had not been resolved. |

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| F 0684<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Provide appropriate treatment and care according to orders, resident’s preferences and goals.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38373<br><br>Based on interview and record review, the facility failed to ensure residents received treatment and care in accordance with professional standards of practice and residents' person centered care plans for 6 (#3, #4, #5, #9, #10 and #12) of 13 (#1, #2, #3, #4, #5, #6, #7, #8, #9, #10, #11, #12, and #13) sampled Residents.<br><br>The facility failed to have a system in place to:<br><br>1. Notify the physician of a low critical Hemoglobin level for Resident #5 and failed to document bleeding monitoring for Resident #5 and Resident #12;<br><br>2. Obtain ordered weekly PT/INR levels for 2 (Resident #5 and Resident #12) of 2 residents receiving Coumadin, (an anticoagulant) therapy;<br><br>3. Ensure medications that included anticoagulant, analgesics, and antidiuretics were administered for Residents #5 and #9;<br><br>4. Obtain and/or monitor blood glucose levels as ordered for Resident #9;<br><br>5. Obtain and/or monitor blood pressure and pulses with medication administration for Resident #9;<br><br>6. Obtain routine laboratory draws as ordered for Residents #3 and #10; and<br><br>7. Ensure physician orders were followed regarding changing Resident #4's suprapubic catheter.<br><br>This deficient practice resulted in an Immediate Jeopardy situation for Resident #5, who had a history of Coumadin toxicity and GI bleed, on 05/20/2024 when the facility failed to obtain an ordered PT/INR level and then failed to notify Resident #5's PCP of a critically low Hemoglobin of 7.5 g/dL and continued to administer Coumadin 7.5mg, an anticoagulant/ blood thinner, to Resident #5 on 05/22/2024, 05/24/2024, and 05/28/2024. Resident #5's PCP discovered the low critical laboratory results during a routine visit on 05/29/2024 and ordered STAT CBC and PT/INR. Resident #5 was subsequently transferred to the hospital on 05/29/2024 diagnosed with Coumadin Toxicity, received a blood transfusion and an injection of Vitamin K, and remained hospitalized through 06/01/2024.<br><br>The deficient practice continued at a potential for more than minimal harm for any resident in the facility who required lab monitoring and notification of changes to their PCP.<br><br>S1 Administrator was notified of the Immediate Jeopardy situation on 10/24/2024 at 3:36 p.m.<br><br>Findings:<br><br>Review of Facility's policy, dated 11/2017, reviewed on 10/08/2024, titled Laboratory Tests read in part . Lab tests are completed as ordered by the physician or physician extender. PT/INR: Initially completed weekly for residents receiving warfarin. If stable and long term may complete monthly.<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Review of the facility's policy titled Notification of a Change in a Resident's Status, dated 11/2017, revealed in part .<br><br>The attending physician/physician extender and the resident's representative will be notified of a change in a resident's condition, per standards of practice and Federal and/or State regulations.<br><br>Guideline for notification of physician/responsible party .<br><br>f. Abnormal lab findings.<br><br>Resident #5<br><br>Resident #5 admitted to the facility on [DATE] with diagnoses that included: Presence of Prostatic Heart Valve, Chronic Atrial Fibrillation, Cerebrovascular Disease, Persistent Mood Disorder, Liver Disease, Chronic Kidney Disease, COPD, Heart Failure, End Stage Renal Disease, and Dependence of Renal Dialysis.<br><br>Review of Resident #5's 05/2024 Physician orders revealed an order to obtain PT/INR every Monday dated Friday, 05/17/2024. Review also revealed an order, dated 05/20/2024, to administer Coumadin 7.5mg every other day. There was no order for bleeding monitoring or bleeding monitoring completed for 05/2024 and 06/2024.<br><br>Review of Resident #5's clinical record revealed there was no evidence a PT/INR had been drawn on Monday, 05/20/2024. Review revealed Resident #5 had a CBC drawn on 05/22/2024 with resulted low critical Hemoglobin of 7.5 which was reported by the laboratory to S6LPN at 2:22 p.m. on 05/22/2024.<br><br>Review of Resident #5's medical record revealed no documentation Resident #5's PCP had been notified of the low critical Hemoglobin on 05/22/2024 or that Resident #5's PT/INR had not been drawn on 05/20/2024.<br><br>Review of Resident #5's 05/2024 EMAR revealed Resident #5 received doses of Coumadin 7.5mg on 05/22/2024, 05/24/2024, and 05/28/2024.<br><br>Review of a progress note for Resident #5, dated 05/29/2024, by S3NP read in part During this evaluation resident told S3NP that she felt like she was bleeding and that she had blood in her stool and has had to have multiple transfusions in the past. She had a critical Hemoglobin on 5/22/2024 of 7.5. S3NP nor MD was notified. S3NP gave orders to obtain PT/INR weekly, however PT/INR has been cancelled in the computer. Stat orders for CBC, PT/INR and fecal occult blood. Results are as follows 05/29/2024 HGB 4.8, HCT 16.6, PT 84.5, and INR 11.02. Orders were given to send patient to ER stat.<br><br>A review off Resident #5's hospital record revealed Resident #5 was hospitalized [DATE] through 06/01/2024 with a diagnosis of Coumadin toxicity, received Vitamin K, and required 1 unit of packed red blood cells to be transfused.<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | In an interview on 10/08/2024 at 9:30 a.m., S6 LPN revealed that when she received a critical lab, she would notify the NP by call or fax. S6 LPN stated with a critical lab like Resident #5's hemoglobin of 7.5, she probably would have texted S3 NP to notify her of the critical lab, and put it in the folder for the NP to sign off on. S6 LPN stated she could not recall the critical lab from 05/22/24, but it was not uncommon for her (Resident #5) to have a critical lab, because Resident #5 had some issues with bleeding but denied observing blood in her stool. S6 LPN stated she couldn't remember receiving the critical lab value from the lab on 05/22/2024.<br><br>In a telephone interview on 10/08/2024 at 9:41 a.m., S3 NP stated her standard practice was for all PT/INRs to be drawn weekly on Monday, and Resident #5's PT/INR should have been drawn on Monday, no matter what was going on. S3 NP stated she was not notified of the critical lab on the day the labs were drawn (05/22/2024), and discovered the lab on 05/29/2024.<br><br>During an interview on 10/09/2024 at 11:45 a.m., S2 DON and S4 Unit Manager revealed they were unsure why Resident #5's PT/INR wasn't drawn on 05/20/2024 but believed the requisition was not put in place after Resident #5 returned from the hospital on 05/16/2024.<br><br>Review of Resident #5's 02/2024 EMAR revealed Coumadin 5mg dose was not documented as given on 02/03/2024.<br><br>Review of Resident #5's EMAR/ETAR revealed monitoring for bleeding was not being done for 05/2024 and 06/2024<br><br>Review of Resident #5's 05/2024 EMAR revealed Coumadin 7.5mg dose was not documented as given on 05/26/2024.<br><br>In an interview on 10/09/2024 at 10:14 a.m., S2 DON revealed the facility received Resident #5's critical H&H lab results on 05/22/2024, and failed to notify the MD or NP of the results, but should have. S2 DON stated the facility failed to ensure Resident #5's ordered PT/INR lab work was completed on 05/20/2024, 05/27/2024 and 06/03/2024, should have been followed up on and ensured that they were completed. S2 DON acknowledged Resident #5 was not being monitored for bleeding/bruising while on Coumadin therapy, but should have been.<br><br>During an interview on 10/24/2024 at 9:15 a.m., S1 Administrator revealed the issue with the labs not being done and the PCP not being notified of critical labs for Resident #5 was not discovered until it was brought to her attention by the surveyors on 10/08/2024 as she, S2 DON and S4 Unit manager were not working at the facility in 05/2024.<br><br>In an interview on 10/24/2024 at 11:48 a.m. with S8 Clinical Operations Nurse revealed after reviewing the Resident #5's 02/2024 and 05/2024 EMAR the 02/03/2024 and 05/26/2024 dose of prescribed Coumadin was missed and she believe agency staff worked the shifts and there is no documentation in nurses notes as to why the Coumadin wasn't given.<br><br>Resident #12<br><br>Review of Resident #12's medical record revealed an admitted [DATE], with diagnoses that included in part . Aortic Valve Replacement, Cerebral Infarction due to Thrombosis, and Schizoaffective Disorder - Bipolar type.<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Review of Resident #12's current physician orders revealed the following, in part .<br><br>01/18/2024: Warfarin Sodium (Coumadin) 4mg, Give 2 tabs (8mg) by mouth every evening; and 11/03/2021: PT/INR every Monday.<br><br>Review of Resident #12's Annual MDS with an ARD of 08/08/2024, revealed a BIMS score of 14, which indicated intact cognition. Review of the MDS revealed the resident required set up or clean up assistance with eating, and resident was independent with rolling left and right, lying to sitting on bed side, sitting to standing, and chair/bed to chair transferring.<br><br>Review of Resident #12's Care Plan with a target date of 11/08/2024 revealed a problem of At risk for abnormal bleeding related to use of anticoagulant medications - related to presence of artificial heart valve, with a target date of 11/08/2024. Interventions included: administer medications as ordered, obtain lab work as ordered, and notify physician of results when available, nurse to monitor for active bleeding and bruising . if noted, notify MD, monitor for signs and symptoms of bleeding IE: bruising, black tarry stools, bright red vomit, coffee ground brown vomit, and red/pink/tea colored urine. Coumadin 8mg by mouth every evening.<br><br>Review of Resident #12's 09/2024 EMAR revealed Resident #12 received 8mg of Coumadin every evening at 4:00 p.m. Review of the 09/2024 MAR revealed nurses were to monitor for active bleeding and bruising every shift, and notify MD if noted, due to Resident #12 on daily Coumadin therapy. The 09/2024 MAR revealed monitoring for active bleeding, was not documented on the 6:00 a.m. - 6:00 p.m. shift on 09/15/2024 and 09/19/2024 or on the 6:00 p.m. - 6:00 a.m. shift on 09/24/2024 and 09/25/2024.<br><br>Review of Resident #12's 10/2024 EMAR revealed Resident #12 received Coumadin daily, and monitoring for bleeding and bruising was not documented on the 6:00 a.m. - 6:00 p.m. shift on 10/03/2024.<br><br>Interview with S1 Administrator on 10/08/2024 at 10:00 a.m., and review of Resident #12's medical record revealed Resident #12's PT/INR was last obtained on Tuesday, 09/03/2024, although it was ordered to be checked every Monday.<br><br>Review of a Progress Note for Resident #12 dated 09/23/2024, by S3 NP, revealed in part .<br><br>History of present illness: He continues to refuse PT/INR due to him not liking the phlebotomist. Education provided on the importance of this lab .contacted unit managers for further assistance.<br><br>In a telephone interview on 10/08/2024 at 10:30 a.m., S3 NP stated a PT/INR was supposed to be drawn every week for Resident #12. S3 NP stated after about two weeks of refusals, she went to talk to the resident, who told her he didn't like the phlebotomist, and refused to let her (the phlebotomist) draw it. S3 NP stated the resident agreed to let staff draw it. S3 NP reported she then talked to staff and asked them to draw it, and they agreed, but stated she hasn't received any results yet.<br><br>In a telephone interview on 10/08/2024 at 11:05 a.m., S4 Unit Manager stated she couldn't recall if, or when she and S3 NP discussed staff drawing Resident #12's lab. S4 Unit Manager said she did recall having a conversation with S3 NP about Resident #12 refusing lab draws, but couldn't remember when it was. S4 Unit Manager stated she called the lab and asked them if they could send a different phlebotomist, and was told they could try. S4 Unit Manager stated she couldn't remember if she had followed up to see if Resident #12's blood was drawn, and didn't know if it had been.<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | In a telephone interview on 10/08/2024 at 12:20 p.m., the Supervisor at the lab confirmed Resident #12 had refused to have his lab work drawn on 10/07/2024, 09/30/2024, 09/24/2024, 09/23/2024, 09/18/2024, and 09/17/2024 and said it was reported to S5 LPN. The lab Supervisor stated she did not see any documentation of anyone from the facility calling to request a different phlebotomist for Resident #12, but said they could change the time for his lab draw, and it would be a different phlebotomist.<br><br>In a telephone interview on 10/08/2024 at 12:24 p.m., S5 LPN revealed she worked from 6:00 p.m. to 6:00 a.m. shift, and confirmed Resident #12 refused to let the lab draw his blood. S5 LPN stated Resident #12 doesn't want to be woken up in the middle of the night. S5 LPN stated she knew S4 Unit Manager was aware; however, no one had ever asked her to draw it.<br><br>In an interview on 10/09/2024 at 1:00 p.m., S2 DON confirmed Resident #12 had not had a PT/INR level drawn since 09/03/2024, and stated no staff had attempted to draw it because they weren't aware they needed to draw it until yesterday. S2 DON stated she was unaware S3 NP had asked anyone in the facility to draw the resident's blood. S2 DON confirmed Resident #12 had orders to receive Coumadin 8 mg daily, and an order to have his PT/INR drawn weekly. S2 DON acknowledged the facility had continued to give Resident #12 Coumadin every day, although they were aware his lab had not been drawn in over a month. S2 DON acknowledged there was no documentation of Resident #12 being monitored consistently on each shift for bleeding or bruising.<br><br>Resident #9<br><br>Review of Resident #9's medical record revealed an admitted [DATE] with diagnoses that included: Hemiplegia, Cerebral Infarction, Type 2 DM, Bladder Disorder, and Nocturia.<br><br>Review of Resident #9's current physicians' orders revealed the following:<br><br>09/12/2023: Novolog 100 unit/ml vial bid-<br><br>60-199=0 units<br><br>200-250=2 units<br><br>251-300=4 units<br><br>301-350=6 units<br><br>351-400=9 units<br><br>401-give 12 units, recheck in 15 minutes, if still greater than 400, call me.<br><br>08/28/2024: Lidocaine 4% patch-apply one patch at HS and note remove in am<br><br>09/18/2024: Desmopressin Acetate 0.2mg PO at bedtime<br><br>Review of Resident #9's 09/2024 EMAR revealed the following:<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Resident #9 did not receive his Lidocaine 4% patch on 09/05/2024.<br><br>Resident #9 did not receive his Desmopressin Acetate 0.2mg by mouth on 09/25/2024 and 09/26/2024.<br><br>Resident #9's accucheck/blood glucose levels were not documented 13 times in 09/2024, as ordered.<br><br>Resident #9's blood pressure and pulse were not documented bid with blood pressure medication administration on 34 occasions during the month.<br><br>In an interview on 10/09/2024 at 10:25 a.m., S2 DON acknowledged Resident #9's 09/2024<br><br>EMAR had missed documentation of vital signs, blood glucose levels, a Lidocaine patch application, and two doses of Desmopressin, as ordered, and shouldn't have.<br><br>Resident #10<br><br>Review of Resident #10's medical record revealed an admitted [DATE] with diagnoses that included in part . Type 2 DM, Chronic Kidney Disease, and End Stage Renal Disease.<br><br>Review of the current physician's orders revealed the following orders:<br><br>05/20/2024: Vitamin D3 1000 unit tablet every day<br><br>09/19/2024: Vitamin D level on 9/20/2024.<br><br>Review of Resident #10's medical record revealed no documented evidence of a Vitamin D level being drawn on 09/20/2024.<br><br>In an interview on 10/09/2024 at 1:14 p.m., S2 DON and S3 Unit Manager confirmed the Vitamin D level for Resident #10 was not drawn on 09/20/2024, as ordered, but should have been. S2 DON and S3 Unit Manager both stated they didn't know why it was not drawn, as ordered.<br><br>Resident #3<br><br>Review of Resident #3's medical record revealed an admitted [DATE] with diagnoses that included: Anoxic brain damage, Cerebral Infarction, Type 2 DM, Neuromuscular dysfunction of bladder, Persistent Atrial fibrillation, and Schizoaffective disorder.<br><br>Review of Resident #3's Physician's orders revealed the following:<br><br>06/07/2024: CBC, CMP, TSH, Mag (Magnesium) level every 6 months (Jan/July)<br><br>Review of Resident #3's medical record revealed no magnesium level was completed as ordered.<br><br>In an interview on 10/09/2024 at 11:19 a.m., S2 DON revealed the magnesium level for Resident #3 was not drawn in July 2024 as ordered by the physician, but should have been.<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | In an interview on 10/09/2024 at 1:16 p.m., S2 DON and S4 Unit Manager revealed that they did not know why the magnesium lab was cancelled for 07/2024.<br><br>Resident #4<br><br>Review of Resident #4's medical record revealed an admitted [DATE] with diagnoses that included Multiple Sclerosis, Neuromuscular Dysfunction, Schizophrenia, Major Depressive Disorder, Specified Anxiety Disorder, Type 2 DM, and Pressure ulcer to left heel.<br><br>Review of Resident #4's Physician Orders revealed the following:<br><br>06/28/2024 Irrigate suprapubic catheter with 60 ml sterile water as needed<br><br>06/26/2024 May change Suprapubic catheter if needed<br><br>05/20/2024 Suprapubic catheter care with soap and water every shift<br><br>Review of Resident #4's Care plan, with a review date of 11/20/2024, revealed Alteration in Elimination related to resident has suprapubic catheter. An intervention included on 08/12/2024 to change Suprapubic catheter every 2 weeks and PRN. Urology to follow up.<br><br>Review of Resident #4's medical records revealed a physician order dated 08/12/2024 to change resident's suprapubic catheter every two weeks and prn. Review of Resident #4's medical records revealed documentation that Resident #4's suprapubic catheter had not been changed on 08/12/2024, 09/09/2024 or 09/23/2024, as scheduled. S2 DON confirmed the suprapubic catheter had not been changed as ordered, but should have been.<br><br>The Immediate Jeopardy was removed on 10/25/2024 at 10:47 a.m., when the facility submitted an acceptable plan of removal, and the surveyors determined through record reviews, interviews, and observations that the Plan of Removal had been initiated and/or implemented.<br><br>Corrective action<br><br>1. On 10/09/2024 at 5:00 p.m., an in-service was initiated for licensed nurses on ensuring critical labs are immediately communicated to the MD/NP for proper treatment and that ordered labs are obtained; in-servicing completed 10/12/2024.<br><br>2. On 10/17/2024 Clinical Operation Consultants initiated 100% audit of all labs from 09/2024 and 10/17/2024 to ensure compliance with lab orders. Any concerns were immediately addressed. Continue to monitor daily x4 weeks.<br><br>3. On 10/21/2024, Clinical Operations Consultant completed 100% lab verification with Nurse Practitioner to ensure facility had correct lab ordered.<br><br>4. On 10/08/2024, Clinical Operations Consultant started lab audit to ensure any critical labs were communicated to MD/NP as warranted as well to ensure ordered labs obtained. This continues as an ongoing audit with lab orders/routine labs follow up with Nurse Practitioner.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 195293 | A. Building<br>B. Wing | 10/25/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Natchitoches Nursing and Rehabilitation Center,llc | 750 Keyser Avenue<br>Natchitoches, LA 71457 |

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

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|---|---|
| F 0684<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | 5. Executive Director, Director of Nurses and Clinical Operations Nurse's employment was separated 05/24/2024 prior to facility gaining knowledge of alleged deficient practice.<br><br>6. On 10/09/2024, Charge Nurse received corrective counseling by Executive Director regarding not communicating critical labs to the physician/nurse practitioner.<br><br>7. On 10/24/2024, Staff Development Coordinator initiated educational in-servicing of all nurses regarding following physician orders. All agency nurses to be trained prior to next shift<br><br>8. Daily morning meetings with interim Director of Nurses and Unit Manager initiated 10/24/2024 where all physician orders from the day before are reviewed to ensure all properly followed up on.<br><br>9. On 10/24/2024 reviewed general medication administration policy and initiated in-servicing of all nurses regarding administering ordered medication. All agency nurses and staff nurses to be trainer prior to next shift.<br><br>10. On 10/24/2024 reviewed insulin administration policy and initiated in-servicing of all nurses regarding properly documenting all blood sugar results. All agency nurses and staff nurses to be trained prior to next shift.<br><br>11. On 10/24/2024 reviewed lab policy and initiated in-servicing of all nurses regarding obtaining all ordered lab and notifying MD/NP of critical labs. All agency nurses and staff nurses to be trained prior to next shift.<br><br>12. Clinical Operations Nurse or designee will monitor morning meeting with Director of Nurses and Unit Manager to ensure all orders are properly completed and followed up on five days a week x 4 weeks.<br><br>13. The facility asserts that their will be no further likelihood for any serious harm to any residents. The likelihood for serious harm to residents no longer exists.<br><br>Facility Completion date: 10/25/2024. |

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| F 0835<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Administer the facility in a manner that enables it to use its resources effectively and efficiently.<br><br>46773<br><br>Based on record review and interview, the facility failed to administer its resources effectively to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident for 6 (#3, #5, #4, #9, #10 and #12) of 13 sampled residents (#1, #2, #3, #4, #5, #6, #7, #8, #9, #10, #11, #12 and #13).<br><br>The Facility failed to:<br><br>1. Ensure there was a system in place to monitor the completion of laboratory draws and timely communication of abnormal lab results to the provider; and<br><br>2. Follow and implement physician's orders for residents who required bleeding and glucose monitoring, routine labs, medication administration and catheterization.<br><br>This deficient practice resulted in an Immediate Jeopardy situation for Resident #5, who had a history of Coumadin toxicity and GI (gastrointestinal) bleed, on 05/20/2024 when the facility failed to obtain an ordered PT/INR level, failed to notify #5's PCP (primary care physician) of a critically low Hemoglobin of 7.5 g/dL and continued to administer Coumadin 7.5mg, an anticoagulant/ blood thinner, to Resident #5 on 05/22/2024, 05/24/2024, and 05/28/2024. Resident #5's PCP noticed the low critical laboratory results during a routine visit on 05/29/2024 and ordered STAT CBC and PT/INR. Resident #5 was subsequently transferred to the hospital where she received a blood transfusion and injection of Vitamin K.<br><br>The deficient practice continued at a potential for more than minimal harm for any resident in the facility who required lab monitoring and notification of changes to their PCP.<br><br>S1 Administrator was notified of the Immediate Jeopardy on 10/24/2024 at 3:36 p.m.<br><br>Findings:<br><br>Cross Reference F684<br><br>Review of the facility's policy revised 11/2017 titled Laboratory Tests revealed in part .<br><br>Lab tests are completed as ordered by the physician or physician extender .<br><br>Responsibility:<br><br>All Licensed Nursing Personnel monitored by Director of Nursing or Designee.<br><br>7. Any labs not obtained as indicated will be rescheduled by the Licensed Nurse.<br><br>(continued on next page) |

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| F 0835<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | 9. The Licensed Nurse, or designee, will forward the lab results to the appropriate IDT nursing and dietary staff for review. The physician/physician extender will be promptly notified of abnormal results according to facility policy.<br><br>Resident #5<br><br>In an interview on 10/09/2024 at 10:14 a.m., S2 DON revealed the facility received Resident #5's critically low Hemoglobin lab results on 05/22/2024 at 2:22 p.m., and failed to notify the MD or NP of the results, but should have. S2 DON confirmed the facility failed to ensure Resident #5's ordered PT/INR lab work was completed on 05/20/2024, 05/27/2024 and 06/03/2024, and should have been followed up on but was not. S2 DON acknowledged Resident #5 was not being monitored for bleeding/bruising while on Coumadin therapy, but should have been.<br><br>In an interview on 10/24/2024 at 9:15 a.m., S1 Administrator acknowledged the facility's multiple quality of care issues being cited. S1 Administrator reported the facility has had a high turnover rate in administrative leadership positions, such as the Administrator, DON, and Clinical Operations Nurse positions, which may have attributed to many of these care issues.<br><br>An interview on 10/24/2024 at 11:48 a.m. with S8 Clinical Operations Nurse revealed after reviewing Resident #5's 02/2024 and 05/2024 EMAR, the 02/03/2024 and 05/26/2024 dose of prescribed Coumadin was missed. S8 Clinical Operations Nurse believed agency staff worked the shifts and there was no documentation in nurses' notes as to why the Coumadin wasn't given.<br><br>Resident #12<br><br>In an interview on 10/09/2024 at 1:00 p.m., S2 DON confirmed Resident #12 had not had a PT/INR level drawn since 09/03/2024, and stated no staff had attempted to draw it because they weren't aware they needed to draw it until yesterday. S2 DON stated she was unaware S3 NP had asked anyone in the facility to draw the resident's blood. S2 DON confirmed Resident #12 had orders to receive Coumadin 8 mg daily, and an order to have his PT/INR drawn weekly. S2 DON acknowledged the facility had continued to give Resident #12 Coumadin every day, although they were aware his lab had not been drawn in over a month. S2 DON acknowledged there was no documentation of Resident #12 being monitored consistently on each shift for bleeding or bruising.<br><br>Resident #9<br><br>In an interview on 10/09/2024 at 10:25 a.m., S2 DON acknowledged Resident #9's 09/2024 EMAR had missed documentation of vital signs, blood glucose levels, a Lidocaine patch application, and two doses of Desmopressin, as ordered, and shouldn't have.<br><br>Resident #10<br><br>In an interview on 10/09/2024 at 1:14 p.m., S2 DON and S3 Unit Manager confirmed the Vitamin D level for Resident #10 was not drawn on 09/20/2024, as ordered, but should have been. S2 DON and S3 Unit Manager both stated they didn't know why it was not drawn, as ordered.<br><br>Resident #3<br><br>(continued on next page) |

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|---|---|
| F 0835<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | In an interview on 10/09/2024 at 11:19 a.m., S2 DON revealed the magnesium level for Resident #3 was not drawn in 07/2024 as ordered by the physician, but should have been.<br><br>In an interview on 10/09/2024 1:16 p.m., S2 DON and S4 Unit Manager revealed that they did not know why the magnesium lab was cancelled for 07/2024.<br><br>Resident #4<br><br>Review of Resident #4's medical records revealed a physician order dated 08/12/2024 to change resident's suprapubic catheter every two weeks and prn. Review of Resident #4's medical records revealed documentation that Resident #4's suprapubic catheter had not been changed on 08/12/2024, 09/09/2024 or 09/23/2024, as scheduled. S2 DON confirmed the suprapubic catheter had not been changed as ordered, but should have been.<br><br>The Immediate Jeopardy was removed on 10/25/2024 at 10:47 a.m. when the facility submitted an acceptable plan of removal, and the surveyors determined through record reviews, interviews, and observations that the Plan of Removal had been initiated and/or implemented.<br><br>Corrective action<br><br>l. On 10/09/2024 at 5:00 p.m., an in-service was initiated for licensed nurses on ensuring critical labs are immediately communicated to the MD/NP for proper treatment and that ordered labs are obtained: in-servicing completed 10/12/2024.<br><br>2. On 10/17/2024 Clinical Operation Consultants initiated 100% audit of all labs from 09/2024 and 10/17/2024 to ensure compliance with lab orders. Any concerns were immediately addressed. Continue to monitor daily x4 weeks.<br><br>3. On 10/21/2024, Clinical Operations Consultant completed 100% lab verification with Nurse Practitioner to ensure facility had correct lab ordered.<br><br>4. On 10/08/2024, Clinical Operations Consultant started lab audit to ensure any critical labs were communicated to MD/NP as warranted as well to ensure ordered labs obtained. This continues as an ongoing audit with lab orders/routine labs follow up with Nurse Practitioner.<br><br>5. Executive Director, Director of Nurses and Clinical Operations Nurse's employment was separated 05/24/2024 prior to facility gaining knowledge of alleged deficient practice.<br><br>6. On 10/09/2024, Charge Nurse received corrective counseling by Executive Director regarding not communicating critical labs to the physician/nurse practitioner.<br><br>7. On 10/24/2024, Staff Development Coordinator initiated educational in-servicing of all nurses regarding following physician orders. All agency nurses and staff nurses to be trained prior to next shift.<br><br>8. Daily morning meetings with interim Director of Nurses and Unit Manager initiated 10/24/2024 where all physician orders from the day before are reviewed to ensure all properly followed up.<br><br>(continued on next page) |

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|---|---|
| F 0835<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | 9. On 10/24/2024 reviewed general medication administration policy and initiated in-servicing of all nurses regarding administering ordered medication. All agency nurses and staff nurses to be trained prior to next shift.<br><br>10. On 10/24/2024 reviewed insulin administration policy and initiated in-servicing of all nurses regarding properly documenting all blood sugar results. All agency nurses and staff nurses to be trained prior to next shift.<br><br>11. On 10/24/2024 reviewed lab policy and initiated in-servicing of all nurses regarding obtaining all ordered lab and notifying MD/NP of critical labs. All agency nurses and staff nurses to be trained prior to next shift.<br><br>12. Clinical Operations Nurse or designee will monitor morning meeting with Director of Nurses and Unit Manager to ensure all orders are properly five days a week x 4 weeks.<br><br>13. Executive Director and Director of Nurses in-serviced on 10/24/2024 by [NAME] President regarding ensuring the facility is administered in a manner that uses resources to effectively and efficiently meets the needs of the residents by ensuring there is a system in place to monitor the completion of laboratory draws and timely communication of abnormal lab results to the provider.<br><br>14. [NAME] President of Operations to monitor Executive Director and Director of Nursing weekly x 4 weeks to ensure compliance of corrective action.<br><br>15. The facility asserts that there will be no further likelihood for any serious harm to any resident. The likelihood for serious harm to residents no longer exists.<br><br>Facility Completion date: 10/25/2024. |