| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 035286 | A. Building<br>B. Wing | 10/24/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Sante of North Scottsdale | 17490 North 93rd Street<br>Scottsdale, AZ 85255 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<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** 49399<br><br>Based on clinical record review, staff interviews, and facility policy, the facility failed to ensure one resident (#2) received treatment and care in accordance with professional standards of practice regarding anticoagulant therapy. The deficient practice could lead to risk of bleeding in residents on anticoagulant therapy.<br><br>Findings include:<br><br>Resident #2 was admitted to the facility on [DATE] with the diagnosis that included acute cystitis without hematuria, thrombocytopenia, left bundle branch block, personal history of transient ischemic attack (TIA) and cerebral infraction without residual deficits.<br><br>Review of clinical record dated August 20, 2024 at 09:53 revealed a nurse practitioner progress note Cardiology was consulted given his anticoagulation needs for mechanical aortic valve status post aortic valve replacement. They advised to continue to monitor INR until therapeutic range 2.5-3.5.<br><br>Review of Resident's Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 13.0 which revealed resident was cognitively intact. The MDS included that the resident has a history of anemia, hypertension, hemiplegia, trans ischemic attack (TIA).<br><br>Review of physician order included following orders:<br><br>- Warfarin Sodium oral tablet (anti-coagulant) give 6 mg (milligram) by mouth one time a day every Tuesday and Thursday for A-fib. with order date of August 19, 2024, hold date from September 2 to 3, 2024, hold date from September 5 to 6, 2024, hold date from September 6 to 7, 2024 and hold date from September 10 to 10, 2024 and hold date from September 10 to 25, 2024.<br><br>- Warfarin Sodium oral tablet give 5 mg by mouth one time a day every Monday, Wednesday, Friday, Saturday, Sunday for A-fib with order date of August 19, 2024, hold date from September 2 to 3, 2024, hold date from September 5 to 6, 2024, hold date from September 6 to 7, 2024 and hold date from September 10 to 10, 2024 and hold date from September 10 to 25, 2024.<br><br>- INR (International Normalized Ratio that measures how long it takes for blood to clot) daily on Monday and Thursday for A-fib with start date of August 29, 2024 and d/c (discontinue) date of September 6, 2024.<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 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | - INR daily one time a day for A-fib with start date of September 7, 2024<br><br>Review of clinical record revealed that the resident's INR was at 8.0 on September 5, 2024 and September 7, 2024.<br><br>Review of clinical record dated September 6, 2024 at 16:29 revealed a physician's progress note that stated that the resident's INR was elevated on September 6, 2024. It further included for September 5, 2024 to hold coumadin x 3 days and stated to not dose vitamin K.<br><br>However, the review of September MAR (Medication Administration Record) revealed that warfarin sodium 5 mg was administered at 1700 on September 7, 2024. The INR result on September 7 was 8.0 which is above the therapeutic range of 2.5-3.5. In addition, the physician progress note dated September 6, 2024 stated to hold coumadin for 3 days.<br><br>The MAR revealed that warfarin sodium 5 mg was administered at 1700 on September 8. Review of clinical record revealed that the resident's INR result on September 8 was 10.0 which is above the therapeutic range of 2.5-3.5.<br><br>The September MAR revealed that the Warfarin was on hold and not administered on September 9 through 11, 2024.<br><br>The INR result was 10.0 on September 9, 2024, 1.2 on September 10, 2024 and 10.0 on September 11, 2024.<br><br>Review of clinical record dated September 11, 2024 at 10:05 revealed a nurse practitioner note that stated the resident was unresponsive, leaning towards the right side, looking right, and drooling. B/P (blood pressure) and HR (heart rate) was elevated, O2 sats (oxygen saturation) 99%. The note stated MD (Medical Director) was called and 911 called, patient was sent to the hospital for workup.<br><br>Review of clinical record dated September 11, 2024 at 16:53 revealed resident #2 was not feeling well, started to vomit, had an altered mental status and right-side deficit, 911 was called and then transported out.<br><br>An interview was conducted on October 24, 2024 at 12:29 pm with a licensed practical nurse (LPN)/Staff #30. Staff # 30 stated that for patient on warfarin, they monitor INR because of the risk of bleeding. When INR levels are above 2 or abnormal, they have to taper the medication up and down. The INR are scheduled and some are done daily, they check the INR level at 5:00 am, and the INR are check with their machine that looks like a blood sugar check machine, and the night shift does the INR check and they order any laboratory works for those unable to get the INR. She stated that she will call the doctor if their INR level is abnormal. If the INR is drawn by the laboratory staff, the charge nurses will notify the doctor or the floor nurse. If night nurse drew the INR blood, it is given through report to the morning nurse and they notify the doctor. Once they get notified if above range, she follows the doctor's order. In addition, she stated that they are monitoring patients on blood thinners by watching for bruising, throwing up, and observing the color of their emesis and poop if there are any signs of bleeding.<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | An interview was conducted with the director of nursing (DON)/Staff #20 on October 24, 2024 at 1:19 pm. The DON stated that the process for laboratory blood drawing is they receive orders from the physician and then go through outside company to draw the ordered labs. The laboratory tech comes in the morning and collect the lab and in an hour the results populate in the patient's chart, and then they report abnormal labs to the physician such as CBC (complete blood count), BMP (basic metabolic panel). She stated that for Point of Care testing such as accuchecks, PCR (viral testing), c-diff and MRSA, and INRs. She stated for INRs that are ordered daily, it is out sourced to outside lab, the results are logged in patient's chart under Results Tab in PCC (Point Care Click). She stated that they do not draw their own INR, there is no Point of Care testing for INRs.<br><br>An interview was conducted with the administrator/Staff #25 on October 24, 2024 at 3:31 pm. Staff #25 stated that the process for patient on blood thinners is they are monitored for signs and symptoms of bleeding. Staff #25 stated that they do PT(pro time)/INR and their PT/INR depends on doctor's order, depends on type of anticoagulant. She stated that the PT/INR are drawn per finger stick and laboratory draw. Staff #25 stated they have a point of care testing for INR like a fingerstick. She stated that there is no quality control for INR checks according to manufacture it is built in the system. The administrator stated that if INR is questionable, especially if the staff know the patient well, they will ask the doctor for a laboratory draw. The administrator stated that they cannot administer coumadin until they get the INR result. The administrator stated that in the MAR, a check mark means it is done, given or completed medication administered. In addition, the administrator stated that the process when patient is on coumadin, they monitor signs and symptoms of bleeding, labs as ordered by the physician for therapeutic levels, they report laboratory result to physician so to make changes with dosing.<br><br>Review of facility policy titled, Medication and Treatment Orders, revised July 2016 revealed (14) orders for anti-coagulants will be prescribed only with appropriate clinical and laboratory monitoring. (a) The attending physician must periodically record in the progress notes the results of the laboratory monitoring and review for potential complications. |