STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075275	A. Building B. Wing	04/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Grimes Center	1354 Chapel St New Haven, CT 06511

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37293 Based on review of the clinical record, review of facility documentation, and interviews for 1 sampled resident (Resident #145) reviewed for medication error, the facility failed to ensure a laboratory test was obtained per physician's order for a resident receiving an anticoagulant medication which resulted in a significant medication error as the anticoagulant medication was not administered for 13 days. The findings include: Resident #145 was admitted to the facility in January 2023 with diagnoses which included prosthetic heart valve, endocarditis, atherosclerotic heart disease, and congestive heart failure. The admission MDS assessment dated [DATE] identified Resident #145 had severely impaired cognition and required extensive assistance with personal hygiene. The January 2023 care plan dated identified Resident #145 was at risk for abnormal bleeding related to use of anticoagulation status-post Surgical Aortic Valve Replacement (SAVR). Interventions included administering anticoagulant as ordered, schedule laboratory tests as ordered by the physician to monitor coagulation factors and report abnormal results to the physician. A physician's order dated 2/1/23 directed to administer Coumadin (anticoagulant medication) 4mg at bedtime until 2/2/23. The nurse's note dated 2/2/23 at 4:32 PM identified laboratory test INR (International Normalized Ratio) (blood test that tells how long it takes for blood to clot) result was 2.1. APRN was notified with a new order for Coumadin 4mg at bedtime was obtained and to . check laboratory test INR on 2/7/23. Review of the Medication Administration Record (MAR) dated 2/1/23 - 2/28/23 identified Resident #145 received Coumadin 4mg at bedtime on 2/1/23 through 2/6/23. The MAR failed to reflect documentation that Coumadin was given on 2/7/23 through 2/19/23 (total of 13 days without Coumadin). Coumadin 5mg at bedtime was then restarted on 2/20/23. Review of the MAR dated 2/1/23 - 2/28/23 identified LPN #2 signed on 2/7/23 that laboratory test INR was obtained. A review of Resident #145's clinical record failed to reflect documentation that a laboratory test INR was obtained on 2/7/23. Review of the nurse's note and nursing assessment dated [DATE] through 2/28/23 failed to reflect documentation of Resident #145 had a laboratory test for INR on 2/7/23 and missed 13 days of Coumadin therapy. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the protime and INR lab results report dated 2/20/23 identified prothrombin time 11.6 and INR 1.10 (therapeutic range: 2.0 - 3.0). A physician's order dated 2/20/23 direct to administer Coumadin 5mg at bedtime until 2/23/23. Check laboratory test INR on 2/23/23. The reportable event report dated 2/24/23 at 10:30 AM identified Resident #145 did not receive Coumadin for 13 days. Resident #145 laboratory test INR result was 1.10 on 2/20/23 when the discovered missed Coumadin doses was noted. Per the cardiologist, Resident #145 therapeutic range was 2.0 - 3.0. Resident #145 was restarted on Coumadin. The cardiologist, MD #1, and the Administrator were made aware of the medication error. Resident #145 was alert and confused. Laboratory test INR ordered, and Coumadin dose was changed based off the INR result. The interview and clinical record review with LPN #2 on 4/8/24 at 2:57 PM identified she was responsible for obtaining the INR on 2/7/23 at the beginning of the shift 7:00 AM - 3:00 PM shift. LPN #2 indicated she tried to do the INR twice and could not get a reading from the INR machine. LPN #2 indicated she notified RN #2 who informed her that INR was going to be done by the laboratory. LPN #2 indicated she did not follow up to see if the INR was done. Interview with APRN #1 on 4/9/24 at 12:29 PM identified she was aware of the issue the same day the error was discovered. APRN #1 indicated the facility notified her Resident #145 INR was not obtained on 2/7/23 as ordered and the Resident #145 did not receive Coumadin from 2/6/23 to 2/20/23. APRN #1 indicated on 2/20/23 she ordered labs and Coumadin 5mg at bedtime. APRN #1 indicated the nursing staff should have followed the physician's order and make sure the INR was done on 2/7/23. APRN #1 indicated there were no adverse effects or clinical changes to Resident #145. Although attempted, an interview with MD #2 (cardiologist) was not obtained. Review of the facility INR (International Normalized Ratio) (blood test that tells you how long it takes for your blood to clot) Testing policy identified to assess blood coagulation level. Licensed nursing staff will perform this procedure per physician's order. Review of the facility drug administration guidelines policy identified to provide a standard administration time for medication at the facility. All nurses will follow the five guidelines to ensure safe drug administration include the right resident/patient, the right drug, the right dose, the right route, and the right time/frequency.