STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165472	A. Building B. Wing	10/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Scenic Manor	1409 Fremont Street Iowa Falls, IA 50126

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 0710 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Obtain a doctor's order to admit a resident and ensure the resident is under a doctor's care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25854 Based on clinical record review, staff, and provider interviews, the facility failed to properly obtain a physician order for a resident admitted to the facility on Coumadin/warfarin (an anticoagulant or blood thinner medication) after discharge from the hospital (Resident #3). Resident #3 admitted to the facility from the hospital following an admission related to acute strokes and atrial fibrillation (AF - rapid heart rate caused by poor blood flow). Resident #3 required the use of Coumadin to help prevent blood clots to prevent future strokes. When he admitted to the facility, the facility failed to ensure he had an order on admission to monitor the therapeutic levels of Coumadin. Resident #3 didn't have the thickness of his blood (INR) checked until 3 weeks after his admission to the facility, when he admitted to the hospital for pneumonia. When the hospital checked his INR, the result reflected a level of 8.85 (therapeutic is 2-3), reflecting an INR level 3-4 times higher than therapeutic. The facility reported a census of 65 residents. Findings include: Resident #3's Minimum Data Set (MDS) assessment dated [DATE] listed an admitted [DATE]. The MDS included diagnoses of medically complex conditions, nonrheumatic mitral valve insufficiency (causes blood to flow backwards into the heart), nonrheumatic aortic valve stenosis (aortic valve narrowed so blood flow became difficult to get into the heart). The assessment indicated Resident #3 stood 5 foot 6 inches tall and weighed 158 pounds. He used an anticoagulant (blood thinner), anti-platelet (makes the platelets more slippery to prevent sticking) and hypoglycemic (low blood sugar) medications within the lookback period. A Clinical Discharge Summary form dated 5/8/24 indicated Resident #3 arrived at the hospital on 5/1/24 at 12:55 AM with active diagnosis that included AF, Heart Failure (HF), Mitral insufficiency, Aortic Stenosis, an anticoagulation goal of an INR of 2 to 3 and Type 2 Diabetes Mellitus (DM). (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 0710 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The History and Physical Final Report dated 5/8/24 listed Resident #3 admitted to the hospital on 5/1/24 and discharged [DATE]. The report indicated Resident #3's hospital stay included a Magnetic Resonance Imaging (MRI) test that diagnosed him with new strokes. The primary care provider (PCP) ordered a neurology referral. The Neurologist directed to start Aspirin (ASA) therapy. Resident #3's hospital admission included diagnoses of an acute CVA (Cerebrovascular Accident/strokes), AF, chronic anticoagulation with warfarin, elevated troponin (lab test to determine the amount of heart muscle damage), aortic stenosis (narrowing of the aortic value opening, which impedes the flow of blood from the heart to the rest of the body) and scattered subtle acute/subacute bilateral cerebral hemisphere lacunar infarcts (small asymptomatic strokes that occurred in both sides of the brain caused by blockages in tiny penetrating arteries). His lab work reflected an INR result on 5/8/24 at 5:38 AM of a 1.8 ratio (high). The provider changed the following medication for Resident #3 on discharge: a. Aspirin 81 milligrams (mg) every day (QD). b. Coumadin 5 mg QD. The Discharge Plan lacked an order or recommendations related to when to check Resident #3's PT/INR (used to measure therapeutic levels of Coumadin. Resident #3's May 2024 Medication Administration Record (MAR) form included the following physician orders: a. Aspirin 81 mg QD in the morning (for Paroxysmal AF) administered 5/9/24 thru 5/28/24. b. Warfarin Sodium 5 mg tablet every evening (for Paroxysmal AF) administered 5/8/24 thru 5/28/24. Review of a Flowsheet Print Request form with dates that ranged from 5/8/24 thru 5/29/24 revealed the following PT/INR values: a. No PT/INR drawn from 5/8/24 thru 5/28/24. b. 5/29/24 - 8.85 (high) c. 5.30. 24 - 5.86 (high) d. 6/1/24 - 2.54 (high) The undated Mayo Clinic Laboratories Critical Values/Critical Results List defined a critical value or critical result as a value/result that represents a pathophysiological state at such variance with normal (expected values) as to be life-threatening unless something is done promptly and for which some corrective action could be taken. The list reflected a critical high result for an INR as greater or equal to 5.0. An emergency room Note verified by a Physician on 5/29/24 at 5:27 PM indicated Resident #3's INR registered markedly elevated at 8.8. The hospital received a Physician order to hold his Coumadin. The Note included diagnoses of over anticoagulation therapy, chronic AF, and right lower lobe pneumonia. (continued on next page)

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F 0710 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/10/24 at 2:10 PM the hospital's Licensed Practical Nurse (LPN)/Admission and Discharge Nurse indicated the hospital staff held the resident's Coumadin/Warfarin for four (4) days following his readmission on 5/29/24. During an interview on 10/10/24 at 3:00 PM the hospital's Nurse Practitioner (NP) who cared for Resident #3 explained the hospital's standard of practice with an elevated and/or unstable PT/INR levels as to check the lab value QD until stable, then every other day (QOD), and eventually 1 time a week. The NP indicated the PCP had the primary responsibility to provide lab draw orders upon discharge from the hospital. She would expect the staff at the facility to follow up with his PCP as high PT/INR levels could cause hemorrhages and/or blood clots. During an interview on 10/11/24 at 9:32 AM Resident #3's primary NP's nurse confirmed the clinic's standard of practice for a resident admitted to a nursing facility on Coumadin. If a resident came without lab orders, the facility staff should have called the PCP to clarify those orders. During an interview on 10/11/24 at 9:53 AM Resident #3's primary NP indicated she would expect the hospital to order the labs, however, if they missed the lab orders, she expected the facility staff to follow up with the PCP, specifically with the PT/INR lab orders/values. The NP confirmed Resident #3's primary medical doctor (MD) performed rounds at the facility on 5/14/24, however, the facility staff failed to report to the MD Resident #3 didn't have PT/INR orders upon admission. The NP reported a drop from an 8.85 PT/INR to 5.86 INR as realistic. The NP also indicated with a PT/INR of 8.85 the resident wouldn't have exhibited signs of bleeding from his leg abrasion, sputum, and etcetera (etc.).