STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165602	A. Building B. Wing	02/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Prestige Care Center of Fairfield	400 Highland Street Fairfield, IA 52556

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 0757 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45338 Based on clinical record review, staff interview, and facility policy review the facility failed to follow physician orders for warfarin administration, also known as Coumadin, after one of three residents (Resident #3) had an elevated International Normalized Ratio (INR) lab result of 6.7 on 1/17/25. Previous to this INR result, Resident #3 had an order for warfarin 5.5 mg daily, with a goal of a therapeutic INR range of 2.5 to 3.5. After an INR result of 6.7, a physician order was given to hold Resident #3's warfarin dose on 1/17/25, and starting on 1/18/25 decrease the daily dose from 5.5mg to 5.0mg daily. The Medication Administrator Record (MAR) documented a 5.5mg dose of warfarin administered to Resident #3 on 1/17/25, and 5.5 mg warfarin doses administered on 1/18/25, 1/19/25, and 1/20/25. On 1/21/25, Resident #3 had a repeat INR test with a result of 12.4. Resident #3 admitted to the hospital on 1/21/25 with pneumonia, urinary tract infection and INR of 13. The resident treated with Vitamin K (antidote to warfarin) in the hospital. This deficient practice resulted in an Immediate Jeopardy (IJ) to the health and safety of the resident. The facility reported a census of 65 residents. Findings include: The State Agency informed the facility of the IJ on 2/12/25 at 3:15 PM. The IJ began on 1/17/25, when the resident administered warfarin following INR of 6.7. Facility staff removed the IJ on 2/13/25 at 3:47 PM through the following actions: a. Policy/procedure review/revision by the DON (Director of Nursing)/designee. b. Licensed nurse education on facility policies regarding high-risk medication, anticoagulants, transcribing physician's orders, and notifying the physician when lab values not in the therapeutic range, and re-education on putting in appropriate hold orders. c. Licensed nurse education on appropriate transcription of putting medication on hold. d. Corrective action/one to one education with licensed nurse/Certified Medication Aide identified in deficient practice. The scope and severity lowered from a J to a G at the time of the survey after ensuring the facility implemented education. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0757 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident scored 9 out of 15 on a Brief Interview for Mental Status (BIMS) exam, which indicted the resident had moderately impaired cognition. Per this assessment, the resident took anticoagulant medication. Review of Medical Diagnoses for Resident #3 included dementia, chronic atrial fibrillation unspecified, and presence of prosthetic heart valve. Review of the Care Plan dated 7/22/24 revealed, [Resident #3] is on anticoagulant therapy r/t (related to) Atrial fibrillation, history of CVA (cerebrovascular accident). The intervention dated 7/31/24 revealed, Administer anticoagulant medications as ordered by the physician. The Physician Order dated start date 12/12/24 revealed, warfarin tab 1mg (milligram) with directions to take 1/2 tab (0.5mg) by mouth at bedtime *add to 5mg tablet to make 5.5mg dose*. The Physician Order dated start date 12/12/24 revealed, warfarin tab 5mg with directions to take 1 tablet by mouth daily *add to 0.5mg tablet to make 5.5mg dose*. Review of Hold Orders dated 1/17/25 by Staff D, Licensed Practical Nurse (LPN) revealed the following: warfarin 5mg put on hold on 1/17/25 from 8:27 AM to 8:00 PM, for 0 days due to PT/INR was too high, and warfarin 1mg with instructions to give half tab (0.5mg) put on hold on 1/17/25 from 8:29 AM to 8:00 PM, for 0 days, due to PT/INR too high. Review of the resident's lab results collected 1/7/25 at 7:03 AM, verified on 1/7/25 at 7:12 AM revealed the resident's INR was 3.4. The Provider Note dated 1/14/25 revealed, Patient has atrial fibrillation, anticoagulated with warfarin 5.5mg daily, tolerates well. INR goal 2.5 to 3.5 with a history of mechanical mitral valve. Review of the resident's lab results collected 1/14/25 at 6:15 AM, verified on 1/14/24 at 6:47 AM revealed the resident's INR was 7.3. The Telephone/Verbal Order Form dated 1/14/25 revealed the following: a. Hold warfarin x1 dose b. Recheck INR this upcoming Thursday c. Change INR from weekly to twice weekly. Review of the resident's lab results collected 1/17/25 at 7:24 AM, verified on 1/17/25 at 8:14 AM, revealed the resident's INR was 6.7. The Nursing Note dated 1/17/25 at 8:16 AM revealed, Lab called with critical value INR 6.7; PT (Prothrombin Time) 62.4; provider notified. The Nursing Note dated 1/17/25 at 8:22 AM revealed, New orders received from [Name Redacted], ARNP (Advanced Registered Nurse Practitioner) to hold coumadin on 1-17-25 and change to 5mg daily starting on 1-18-25. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0757 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the resident's MAR dated January 2025 revealed Resident #3 was administered 5.5mg of warfarin on 1/17/25, and revealed Resident #3 received 5.5mg of warfarin on 1/18/25, 1/19/25, and 1/20/25. Review of the resident's lab results collected 1/21/25 at 6:57 AM, verified on 1/21/25 at 7:27 AM, revealed the resident's INR was 12.4. The Nursing Note dated 1/21/25 at 6:36 AM revealed, [Name Redacted] lab was here this a.m. concerned resident was having some altered mental status change. Assessment completed, Resident vitals B/P (blood pressure) 151/80, P (pulse) 114, RR (respiratory rate) 20, O2 (oxygen) 94% T (temperature) 96.8. He is in a pleasant mood, Alert only to self. PT/INR drawn this a.m. Protime is 119.8, INR 12.4. New order received by [Name Redacted] ARNP (Advanced Registered Nurse Practitioner) to transfer resident out to ED (emergency department) for evaluation. Call placed to 911 at 8:08 a.m Report called to [Name Redacted] ED at 8:29 a.m. Notified [family member, name redacted] POA (Power of Attorney). resident was confused and unable to sign bed hold. Notified [Name Redacted] DON (Director of Nursing). Resident transferred to ED at 8:38 a.m. via [Name Redacted] ambulance. Review of the ED Provider Note dated 1/21/25 at 3:10 PM revealed, Patient presents with altered mental status. Pt has altered mental status with elevated INR LTC (long term care) reports 12.4 EMS (Emergency Medical Services) reports 11 pt (patient) is aware of town not building unaware of time oriented to self last known well 2100 (9:00 PM) last night EMS reports had been holding coumadin often due to INR values no recent falls noted hx (history) of heel ulcer and dementia confusion note baseline and demeanor is laughing smiling also not his normal hx UTI (urinary tract infection) noted no Vitamin K administered no hx diabetes. The Hospital Notes further documented, [age-redacted] year-old-male from the nursing home was sent with elevated INR. Patient has no complaints. Patient was Coumadin for atrial fibrillation. Patient was no bleeding no other issues. Continued review of the resident's hospital records dated 1/21/25 revealed, in part, the following per the Impression section: Sepsis with septic shock, likely secondary to hypotension and hypothermia secondary to pneumonia. Patient found to have a supratheraputic INR, was given Vitamin K. Will hold Coumadin at this time .Super therapeutic INR. Vitamin K administered. Recheck in am if no bleeding will not transfuse ffp (frozen fresh plasma) for now. Goal with 2-3. Review of Hospital Records revealed a Progress Note dated 1/22/25 at 12:53 PM by an ARNP which revealed, Chief Complaint: F/U (follow up) septic shock .INR 7.3 after giving vitamin k 5mg x1 in the ER. Review of Recent Results (from the past 24 hours) included as part of the Progress Note revealed the following highest values of PT/INR in the Recent Results section: PT of 125.6 and INR 13.0. On 2/11/25 at 1:19 PM, Staff A, Certified Medication Aide (CMA) queried if only nurses gave Coumadin, and responded believed both did (CMA and nurse). Per Staff A, if medication held she would be told and would also be on the MAR. Per Staff A, report was given in the morning. When queried what it would mean if there was a check on the MAR, Staff A meant, we gave it. (continued on next page)

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F 0757 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 2/11/25 at 3:15 PM, Staff B, CMA, who had signed out Resident #3's Coumadin doses on 1/17/25 with a check mark, queried about Coumadin administration at facility. Staff B acknowledged both CMAs and nurses gave Coumadin if scheduled. When queried how she knew how much to give, Staff B responded on the MAR told you. When queried how she would know if on hold, Staff B responded would say on hold on the MAR, and usually the card turned backwards. Per Staff B, would not show yellow, and would say on hold. When queried what the check on the MAR indicated, Staff B could not explain. On 2/11/25 at 3:21 PM, Staff C, Licensed Practical Nurse (LPN) explained the following about when resident sent out: Lab came to draw that morning, probably PT/INR but Staff C not sure because he (Resident #3) was getting other labs drawn, resident was very confused, and pupils were super dilated. Per Staff C, the resident's vital signs weren't normal for him, went in and changed him, was talking, super confused, was in wheelchair and kept trying to go the dining room and wanted to eat breakfast. Staff C explained as got to talk to him the resident was not acting right, and explained she got a hold of the doctor who said to send him out, and kept him. When queried if the resident was on Coumadin, Staff C acknowledged he was, said it depended on the week, and a lot of weeks changed order, and further explained had to hold the order. Per Staff C, critical labs were an ongoing thing, several days held the coumadin, and explained everything did was not working. When queried who put in Coumadin orders at the facility, Staff C responded pharmacy, and further explained pharmacy put in all orders unless it was a hold. Per Staff C, lab would call a critical, and Staff C or whoever at facility would call the doctor, doctor would say whatever tell to do. Staff C explained could physically go in and hold the medication, and further explained what she did was put an H on the card so the medication aide knew to hold it, and in the computer could put it as a hold. Staff C explained she could not change the order, and if dosage change would have to refax to pharmacy, pharmacy put it in, and then Staff C would confirm the order. When queried if pharmacy could put in hold orders, Staff C responded they could hold it, and facility could always fax for them to hold, [facility] confirm it, and could send to pharmacy or put on hold [at facility level]. Staff C explained she would put H on the card so the medication aide knew, would go into the actual order and update, would go into the order page, hit the arrow down, explained there were different options, and would put the hold on that day. Per Staff C, then [resident] would start the new orders the next day. When queried if she needed to pick times if holding medication, Staff C showed how, if a one time hold order, she could put hold date. When held for one day, the screen showed the date range auto-populated to the next day for end date. Staff C further explained, in part, if on hold staff would not have the option to even click it, and whoever passing pills following MAR literally couldn't click gave it as not existent to push. On 2/11/25 at 4:06 PM, Staff D, Licensed Practical Nurse (LPN) explained generally if had a Coumadin order, would send to the pharmacy and they would put the order in, and explained would need to go in and discontinue old order and confirm the new order. Per Staff D, pharmacy put in all of the orders with the exception of wounds and labs and such, which [facility] could do. Per Staff D, pharmacy put in all the medications, and as the nurse would have to go in and confirm or discontinue for them to appear on the MAR or TAR (Treatment Administration Record). Staff D explained on previous instance had tried to send a hold order to the pharmacy, and the pharmacy sent it back and said the nurse had to put the hold order in. (continued on next page)

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F 0757 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During the telephone interview with Staff D, Staff D was read the note they input for Resident #3 on 1/17/25 at 8:22 AM. Per Staff D, she remembered telling the CMA not to give the Coumadin, and acknowledged she remembered that order. When queried as to the identity of the CMA, Staff D explained she believed it was Staff B. When queried about a hold order in that instance, Staff D explained she could not tell that had ever put in a hold order, was not one hundred percent on how, and explained that was why she had sent hers to the pharmacy. When queried if she needed to select the number of days if put in a hold order, Staff D responded she thought so, she thought could go in and it would ask you, and she was not one hundred percent sure because she did not do a lot of hold orders. When queried if she had received education on how to hold order, Staff D denied. Staff D explained the nurse would have to talk to the CMA before could get into the medication cart, and acknowledged on the 17th (1/17/25), she (Staff D) would not have put a physical notation on the card. On 2/12/25 at 10:15 AM the facility's Director of Nursing (DON) queried about Coumadin orders at the facility, and explained the following: When received order from the physician, would fax to pharmacy, and pharmacy would enter the orders into [facility electronic health record system redacted]. Per the DON, nurses would go back and confirm it. When queried about hold orders, the DON explained nursing staff could hold per physician order and let the pharmacy know. The DON explained with any other dosage change, med change would fax the orders to pharmacy. The DON explained the following about hold orders: Per the DON, would go into [facility electronic health record system redacted], would look under order, and could put update/hold so could hold the medication, and nurses could go ahead and do that if had the order. When queried if staff needed for enter the number of days holding the drug, the DON responded yeah. When queried as to the process to hold one dose, the DON explained would have to put in the specific date and time, ensure time is correct, and acknowledged would need to put 1 day in the day spot. When queried about the process for telephone orders, the DON explained the facility had verbal order forms, would go ahead and fill those out, and would fax to pharmacy. Per the DON, would also depend on what kind of order it was, as the facility could enter lab orders. Per the DON, pharmacy could be involved in the hold process as well, and the DON further explained would send to pharmacy when holding, as was kind of like a double check. The DON queried what a check on the MAR would mean, and responded the medication administered or signed off. The DON explained the facility had several educations with nurses and medication aides, acknowledged included the process for holding, acknowledged H to be present on the bubble pack (medication package), and explained the facility would usually turn that card around on the cart. The DON acknowledged the medication aide would have the only set of keys to the cart, and so staff would have to find the medication aide to put an H (on card) and to flip the card. When queried about Coumadin concerns for Resident #3, explained his had been all over the place for quite awhile, explained the resident's body had been failing for the past two to three months, and seemed to have gotten more out of whack. The DON acknowledged not aware of Coumadin hold concerns for resident. When queried if the resident received the medication on 1/17/25, the DON responded from what she could see, yes, said it could have been accidentally charted, and explained she saw it was checked off. When queried about the resident's MAR for 1/18-1/20/25, DON acknowledged saw 5mg and then 0.5 mg. When queried if aware of concern or new information, the DON responded new information. Per the DON, any new order would have been faxed to pharmacy, facility could do hold orders, and most of the time was pharmacy. (continued on next page)

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F 0757 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 2/12/25 at 11:05 AM, the DON explained the following about the resident's medication to be held on 1/17/25: Per the DON, tracked down the nurse who put the hold order in, explained had been passed to the medication aide and was still popping up, and staff didn't put in the correct code because didn't give it. Per the DON, Staff D had put an H and turned the med around. On 2/12/25 at 12:28 PM, Staff E, Pharmacy Technician interviewed, explained the facility was on [electronic health record system redacted], and was pharmacy initiated. Per Staff E, the pharmacy did not manage hold orders and that was a task the facility would have to implement on their end. Staff E explained the following process for a scheduled Coumadin order: For a dose change, would submit the dose change as well as INR too, and pharmacy would make that as soon as received fax. Staff E explained the following about being pharmacy initiated: The pharmacy would manage entry of all pharmacy orders on the EMAR (electronic medication administration record). Per Staff E, the last scheduled Coumadin orders pharmacy had for resident were 5.5mg dose, received 5mg and 1mg dose (to take half of the 1), to get to 5.5 dose. Per Staff E, those faxes were last sent in December. On 2/12/25 at 12:44 PM, Staff F, Nurse Practitioner (NP) queried about Resident #3. Staff F acknowledged she managed resident's Coumadin at the facility, and explained if was the most difficult Coumadin had to manage. Per Staff F, INR went up and down, and [resident] was very sensitive to any inflammatory infectious process. Staff F explained any time the resident was unwell it would set off his INR really badly. Per Staff F, any little thing physically would make the INR abnormal. The Facility Policy titled Anticoagulants, dated 4/2019 and revised 1/2025, revealed the following: 1. Anticoagulants shall be prescribed by a physician or other authorized practitioner with clear indications for use. Examples include prevention and treatment of deep vein thrombosis, pulmonary embolism, atrial fibrillation with embolization, stroke or management of myocardial infarction. 2. Target symptoms (i.e. lab values) and goals for use (i.e. prevention or treatment) of anticoagulants shall be documented in the resident's medical record. Duration of use shall be appropriate to the resident's condition and indication for use.