STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235384	A. Building B. Wing	06/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Schnepp Senior Care and Rehab Center	427 E Washington Saint Louis, MI 48880

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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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31771 Based on interview and record review, the facility failed to accurately correlate and document Minimum Data Set (MDS) assessment information from the medical record for one Resident (R61) with a history of behaviors resulting in inaccurate assessments, the potential for care areas to not be triggered or identified impeding the development of an individualized Care Plan, and the potential for all facility residents to not be properly assessed and a corresponding plan of care be implemented to enable attainment of their highest potential physical, mental, and psychosocial well-being. Findings: Review of the Electronic Medical Record (EMR) Admission Record reflected R61 admitted to the facility 2/24/23 with pertinent diagnoses that included Alzheimer's Disease and Dementia with agitation. Review of the MDS dated [DATE] reflected a Brief Interview for Mental Status (BIMS) score of 7 out of 15 which indicated R61 was moderately cognitively impaired. Review of the Care plan for R61 revealed a Focus area of I am at risk for alterations in my behavior .may hit myself at times if angry, upset or when staff attempting to assist with (Activities of Daily Living) I will swat at staff when they try to help me ., I have moments when I get angry, and I will lash out at staff and kick at furniture . This Focus area was initiated 2/24/23 and last revised on 6/25/24 (Survey Exit Date). The Care Plan reflected a Goal of Resident will have a decrease in symptoms with no harm to self or others initiated 2/24/23 and last revised 4/13/24. Review of the Center for Medicare and Medicaid Services (CMS) Long-Term Care Resident Assessment Instrument (RAI) 3.0 User's Manual Chapter 2, 2.1 reflects that Medicare and Medicaid certified nursing homes must conduct initial and periodic assessments of all their residents. The Resident Assessment Instrument (RAI) process is the basis for accurate resident assessments recorded on the Minimum Data Set 3.0 assessments. The RAI User's Manual refers to the last day of the resident observation period for the assessment as the Assessment Reference Date or ARD. This observation period, also known as the look back period, is seven days for most MDS 3.0 core items and these items are separated into Sections. Section E is titled Behavior and requires a seven day look back period. Review of the CMS RAI Version 3.0 Manual instructions for Section E: Behavior reflect Intent Once the frequency and impact of behavioral symptoms are accurately determined, follow-up evaluation and care plan interventions can be developed to improve the symptoms or reduce their impact. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/26/24 at 11:56 AM an interview was conducted with Social Services Designee (SSD) I who indicated she completes Section E of the MDS assessments. SSD I reported that R61 has a history of hitting himself. SSD I reported that sometimes staff will have difficulty with daily cares as R61 will hit and kick. SSD I reported when reviewing data for the MDS assessment I look at everything and included, Progress Notes, Behavior notes, Care Plan, psycho-active medication notes, and Doctor notes in the description of the sources reviewed. An MDS assessment with an ARD date of 1/31/24 for R61 is logged in the EMR. The designated look back period would be 1/25/24 through 1/31/24. Review of the Progress Notes for R61 reveled: -Alert Note of 1/25/25 at 3:39 PM, Resident Yelling/Screaming. -Behavior Note 1/28/24 at 11:05 PM (R61) refused all of his (nighttime) meds. Nurse approached multiple times. (R61) began to yell leave me alone. (R61) then began to spit at the nurse and CNA's when they tried to assist him. -Alert Note 1/29/24 at 2:06 PM, Resident Pinch/Scratch/Spit. -Behavior Note 1/30/24 at 1:21 AM reflected, (R61) refused all of his (nighttime) medications. Nurse reapproached multiple times . but says No, I'm not taking anything. (R61) has been spitting at staff .yelling out profanities at staff when cares performed. Review of Section E- Behaviors of the MDS with the ARD date of 1/31/24 completed by SSD I reflected E0200. Behavioral Symptoms, A. Physical behavioral symptoms directed to others as the question with the documented response of 0. Behavior not exhibited. And B. Verbal behavioral symptoms directed towards others (e.g screaming at others, cursing at others) . The documented response to this is 0. Behavior not exhibited. And C. Other behavioral symptoms not directed toward others (e.g verbal/vocal symptoms like screaming, disruptive sounds) with the documented response of). Behavior not exhibited. The next step on this assessment reveals sub-section E0300 and asks if any behavioral symptoms in the previous questions were coded 1,2, or 3. The documented response was 0. No . This No response triggered the assessment to disable or skip over sub-section E0600 which assesses the impact of these behaviors on the resident physically, socially, the risk for injury, or the living environment. The next sub-section that was completed is E0800 Rejection of Care to include rejection of medications and assistance. The documented response is 0. Behavior not exhibited despite documentation during the look back period to the contrary. Review of the EMR Behavior Note dated 4/13/24 at 11:30 PM reflected CNA reported that (R61) was hitting himself when the CNA was assisting (R61) with (nighttime) cares. The Alert Note of 4/16/24 at 8:32 AM reflected Resident Yelling/Screaming. Section E of the MDS with an ARD date of 4/18/24 was reviewed. E0200 of this section, completed by SSD I, reflected documentation that, during the look back period of 4/12/24 to 4/18/24 had not displayed any physical or verbal behaviors. This MDS section reflected that it was signed by (SSD I) on 4/24/24 at 2:34 PM (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the EMR Progress Notes revealed a Social Service Note dated 4/24/24 at 2:30 PM, which is timed 4 minutes prior to the signing of Section E of the MDS dated [DATE]. This note reflected that (R61) does have a (history) of hitting himself, as confirmed by documentation evident during the look back period. However, this information was not included Section E of the MDS assessment.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45410 Based on observation, interview, and record review, the facility failed to 1) perform ordered pressure ulcer interventions and 2) adequately monitor and assess a pressure ulcer for 1 resident (Resident #33) of 2 residents reviewed for pressure ulcer care, resulting in the potential of worsening pressure ulcers and the potential for residents to not meet their highest practicable physical, mental, and psychosocial well-being. Findings include: Review of an Admission Record revealed Resident #33 admitted to the facility on [DATE] with pertinent diagnoses which included a foot ulcer, a pressure ulcer, and peripheral vascular disease. Review of a Minimum Data Set (MDS) assessment for Resident #33, with a reference date of 4/24/2024 revealed a Brief Interview for Mental Status (BIMS) score of 13, out of a total possible score of 15, which indicated Resident #33 was cognitively intact. Review of a current skin management Care Plan intervention for Resident #33, with a revision date of 12/22/2023, directed staff that Resident #33 used a right foam boot when in bed to aid in pressure reduction and possible friction. Review of facility policy/procedure Wound Management Program, Revised 8/17/2027, revealed .To assure that residents who are admitted with, or acquire, wounds receive treatment and services to promote healing, prevent complications and prevent new skin conditions from developing . Complete the following documentation weekly, as applicable to type of wound/skin condition . Weekly pressure ulcer wound documentation and picture in wound rounds . weekly non-pressure wound documentation and picture in wound rounds . Review of Resident #33's Physician's Orders, active 6/26/2024, revealed .Apply foam boot while in bed to offload pressure and prevent friction from rubbing . Right Heel: Cleanse wound with generic wound cleanser, apply hydrofera blue ready to wound bed, cover with ABD pad and wrap with kerlix . Review of Resident #33's electronic medical record on 6/26/2024 at 9:20 AM revealed Resident #33's right heel pressure ulcer was documented as resolved and the facility had not been performing weekly wound assessments, measurements, or pictures since December of 2023. Review of Resident #33's wound clinic documentation, date of service 5/14/2024, revealed .pressure ulcer of right heel, stage 3 . Right calcaneus is slightly worse this week. I obtained wound culture. See new wound orders . keep weight off area of wound at all times . obtain post op shoe and use when not in bed . Prevalon boot (foam protective boot) or equivalent when in bed . Review of Resident #33's wound clinic documentation, date of service 6/4/2024, revealed .pressure ulcer of right heel, stage 3 . Right calcaneus . near healed . keep weight off area of wound at all times . obtain post op shoe and use when not in bed . Prevalon boot or equivalent when in bed . (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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #33's wound clinic documentation, date of service 6/25/2024, revealed .pressure ulcer of right heel, stage 3 . Right calcaneus . still open . keep weight off area of wound at all times . obtain post op shoe and use when not in bed . Prevalon boot or equivalent when in bed . In an interview on 6/26/2024 at 9:20 AM, Licensed Practical Nurse (LPN) A reported she was not sure why the facility was not performing weekly wound measurements and pictures for Resident #33's right heel wound. In an observation and interview on 6/26/2024 at 9:36 AM in Resident #33's room, Resident #33 was in bed and not wearing a foam protective boot. Resident #33 reported she had not worn the foam protective boot for months. Resident #33 reported staff did not offer the foam protective boot to her any longer, and her sister had taken the boot home. Review of Resident #33's June Treatment Administration Record revealed frequent documentation of right foot foam boot use while in bed, including documentation of the foam boot being applied by LPN A on day shift and the evening shift of 6/25/2024. In an observation and interview on 6/26/2024 at 9:42 AM in Resident #33's room, LPN A was unable to find Resident #33's foam protective boot. LPN A reported was not sure when she had last seen the foam protective boot, but it had been at least a few weeks prior. LPN A found a black post op shoe in Resident #33's room and reported Resident #33 had worn this in bed on 6/25/2024 instead of the foam protective boot. LPN A reviewed Resident #33's orders and reported the post op shoe was to be worn when not in bed and the foam protective boot was to be worn while in bed according to current orders. LPN A reported she documented Resident #33 wearing the foam protective boot on 6/25/2024 in error. In an interview on 6/26/2024 at 9:57 AM, the Director of Nursing (DON) reported she could not find documentation of weekly wound measurements or pictures for Resident #33 except from the wound clinic. In an interview on 6/26/2024 at 11:58 AM, Competency Evaluated Nursing Assistant (CENA) E reported she had not seen Resident #33's foam protective boot in her room since early June. In an interview on 6/26/2026 at 12:03 PM, Regional Clinical Director C reported the facility had not been documenting weekly wound measurements or pictures for Resident #33's right heel wound. Regional Clinical Director C reported documentation should accurately reflect current treatment given. In a telephone interview on 6/26/2024 at 1:07 PM, Wound Nurse Practitioner D reported Resident #33's right heel wound was still open at her appointment on 6/25/2024 and measured 0.1 by 0.1 by 0.1 cm. Wound Nurse Practitioner D reported the wound had never completely healed and was still open. In an interview on 6/26/2024 at 1:33 PM, LPN A reported she reviewed the documentation from the wound clinic when Resident #33 returned on 6/25/2024 and did not realize the documentation reported the wound to be still open or discuss this with facility staff.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30120 Based on interview and record review, the facility failed to ensure the physician reviewed a pharmacy recommendation for 1 of 5 residents (R61) reviewed for monthly pharmacy medication reviews, resulting in the potential for the physician not being aware of a pharmacy recommendation and serious side effects of the combined use of a non-steroidal anti-inflammatory (NSAID) and an anticoagulant. Findings include: A review of R61's Admission Record, dated 6/26/24, revealed R61 was a [AGE] year-old resident admitted to the facility on [DATE]. In addition, R61's Admission Record revealed multiple diagnoses that include right hip pain, chronic atrial fibrillation (an irregular fast heart rate), hypertension, and a history of transient ischemic attack (TIA- a mini-stroke)) and cerebral infarction (CI- a stroke). A review of R61's pharmacy medication regimen reviews, dated 6/1/23 to 6/26/24, revealed the following: - Pharmacy Recommendation, dated 12/7/23, revealed, PHARMACIST RECOMMENDS:: PHYSICIAN RECOMMENDATION: This resident is receiving Mobic (a non-steroidal anti-inflammatory (NSAID) used for pain)15 mg (milligrams) QD (once a day) and receives Eliquis (an anticoagulant- blood thinner- used to prevent blood clots in residents with a history of and/or at risk for strokes and atrial fibrillation) 5 mg BID (twice a day). Please be aware of the following black box warning: Cardiovascular events: [U.S. Boxed Warning]: NSAIDs are associated with an increased risk of adverse cardiovascular events, including MI (myocardial infarction- a heart attack), stroke, and new onset or worsening of pre-existing hypertension. Risk may be increased with duration of use or pre-existing cardiovascular risk factors or disease. Carefully evaluate individual cardiovascular risk profiles prior to prescribing. Use caution with fluid retention, CHF (congestive heart failure), or hypertension . Gastrointestinal (GI) events: [U.S. Boxed Warning]: NSAIDs may increase risk of gastrointestinal irritation, ulceration, bleeding, and perforation. These events may occur at any time during therapy and without warning. Use caution with a history of GI disease (bleeding or ulcers), concurrent therapy with aspirin, anticoagulants and/or corticosteroids, smoking, use of alcohol, the elderly or debilitated patients. Use the lowest effective dose for the shortest duration of time, consistent with individual patient goals, to reduce risk of GI adverse events; alternate therapies should be considered for patients at high risk. Please evaluate current therapy and indicate below the appropriate option for this resident . RESPONSE TO RECOMMENDATION: FOLLOW-UP REQUIRED:: yes. - Pharmacy Recommendation, dated 12/12/23 and written by Clinical Care Coordinator (CCC) F (who was a Registered Nurse), revealed, PHARMACIST RECOMMENDS:: PHARMACIST RECOMMENDS:: PHYSICIAN RECOMMENDATION . (x) A benefit/risk analysis of current therapy warrants continuation at the present dose. Other treatment options have been attempted and this medication improves the quality of this resident's life. The benefits outweigh the risks . RESPONSE TO RECOMMENDATION: no changes to current medication . (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of R61's electronic medical record (EMR), dated 12/7/23 to 6/26/24, failed to reveal a benefit/risk analysis by the Medical Director (MD) G (R61's physician) for the concurrent (combined) use of Mobic and Eliquis. In addition, R61's EMR failed to reveal any documentation by MD G, and/or physician designee (e.g., a nurse practitioner, physician assistant, another physician) (e.g., a progress note or physician note), that MD G was aware of the pharmacy recommendation. During an interview on 6/26/24 at 11:53 AM, the Director of Nursing (DON) stated R61's benefit/risk analysis for Mobic and Eliquis by MD G should be in the Misc (miscellaneous) section of R61's EMR. The surveyor notified the DON that the benefit/risk analysis could not be found in R61's EMR under the Misc section or any other section of R61's EMR. The DON stated she would look and see if she can find it. The surveyor requested a copy of R61's benefit/risk analysis, if it could be found, and the DON verbalized understanding. During a second interview on 6/26/24 at 02:55 PM, the DON stated there was not a benefit/risk analysis done by MD G, or any other physician/physician designee. She also stated she could not find a physician's note that indicated MD G addressed the concurrent use of Mobic and Eliquis. The DON further stated, it is our process that CCC F enters physician recommendations in the Pharmacy Recommendation follow-up notes. The DON also stated that the Pharmacy Recommendation note, dated 12/12/23, must have been the MD G's recommendation because the MD G did not write any new orders and that MD G must have done a benefit/risk analysis because the Pharmacy Recommendation note written by CCC F stated he did, despite not providing this requested documentation. A review of the facility's Consultant Pharmacist Reports IIIA2: Documentation and Communication of Consultant Pharmacist Recommendations Policy and Procedure, dated 9/1/23, revealed, If the prescriber does not respond to recommendation directed to him/her (within 30 days), the Director of Nursing and/or the consultant pharmacist may contact the Medical Director. 1) If the prescriber that does not respond is also the Medical Director, the Director of Nursing and the Administrator will address the requirements with the Medical Director and/or pursue more formal actions if necessary to facilitate compliance. However, no documentation was found or provided after the request for documentation that MD G had been contacted regarding R61's pharmacy recommendation on 12/7/23 and/or any documentation by MD G that he was aware of the pharmacy recommendation. In addition, at the time of the conclusion of the survey and exit from the facility on 4/26/24 at 4:15 PM, the facility failed to provide any documentation that MD G was aware of R61's 12/7/23 pharmacy recommendation.

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F 0757 Level of Harm - Minimal harm or potential for actual harm 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** 30120 Based on interview and record review, the facility failed to ensure the medication regimen for 1 of 5 residents (R61) reviewed was free of unnecessary medications, resulting in the potential for R61 to receive unnecessary medications over an extended period. Findings include: A review of R61's Admission Record, dated 6/26/24, revealed R61 was a [AGE] year-old resident admitted to the facility on [DATE]. In addition, R61's Admission Record revealed multiple diagnoses that include right hip pain, chronic atrial fibrillation (an irregular fast heart rate), hypertension, and a history of transient ischemic attack (TIA- a mini-stroke)) and cerebral infarction (CI- a stroke). A review of R61's Pharmacy Recommendation, dated 12/7/23, revealed, PHARMACIST RECOMMENDS:: PHYSICIAN RECOMMENDATION: This resident is receiving Mobic (a non-steroidal anti-inflammatory (NSAID) used for pain)15 mg (milligrams) QD (once a day) and receives Eliquis (an anticoagulant- blood thinner- used to prevent blood clots in residents with a history of and/or at risk for strokes and atrial fibrillation) 5 mg BID (twice a day). Please be aware of the following black box warning: Cardiovascular events: [U.S. Boxed Warning]: NSAIDs are associated with an increased risk of adverse cardiovascular events, including MI (myocardial infarction- a heart attack), stroke, and new onset or worsening of pre-existing hypertension. Risk may be increased with duration of use or pre-existing cardiovascular risk factors or disease. Carefully evaluate individual cardiovascular risk profiles prior to prescribing. Use caution with fluid retention, CHF (congestive heart failure), or hypertension . Gastrointestinal (GI) events: [U.S. Boxed Warning]: NSAIDs may increase risk of gastrointestinal irritation, ulceration, bleeding, and perforation. These events may occur at any time during therapy and without warning. Use caution with a history of GI disease (bleeding or ulcers), concurrent therapy with aspirin, anticoagulants and/or corticosteroids, smoking, use of alcohol, the elderly or debilitated patients. Use the lowest effective dose for the shortest duration of time, consistent with individual patient goals, to reduce risk of GI adverse events; alternate therapies should be considered for patients at high risk. Please evaluate current therapy and indicate below the appropriate option for this resident. A review of R61's Pharmacy Recommendation, dated 12/12/23, revealed, PHARMACIST RECOMMENDS:: PHARMACIST RECOMMENDS:: PHYSICIAN RECOMMENDATION . (x) A benefit/risk analysis of current therapy warrants continuation at the present dose. Other treatment options have been attempted and this medication improves the quality of this resident's life. The benefits outweigh the risks . RESPONSE TO RECOMMENDATION: no changes to current medication . A review of R61's electronic medical record (EMR), dated 12/7/23 to 6/26/24, failed to reveal a benefit/risk analysis by the Medical Director (MD) G (R61's physician) for the concurrent (combined) use of Mobic and Eliquis. In addition, R61's EMR failed to reveal any documentation by MD G, and/or physician designee (e.g., a nurse practitioner, physician assistant, another physician) (e.g., a progress note or physician note), that MD G was aware of the pharmacy recommendation. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of R61's Medication Administration Records, dated 12/7/24 to 6/26/24, revealed R61 received Mobic 15 mg daily and Eliquis 5 mg twice a day during this period. During an interview on 6/26/24 at 02:55 PM, the Director of Nursing (DON) stated there was not a benefit/risk analysis done by MD G, or any other physician/physician designee, in R61's EMR. She also stated she could not find a physician's note that indicated MD G addressed the concurrent use of Mobic and Eliquis in R61's EMR. As of the time of the conclusion of the survey and exit from the facility on 4/26/24 at 4:15 PM, the facility failed to provide any documentation that MD G had completed a benefit/risk analysis and/or addressed the concurrent use of Mobic and Eliquis. Therefore, due to a lack of documentation in R61's EMR by MD G regarding the concurrent use of Mobic and Eliquis based on the benefits versus risks to R61 and R61 had received them concurrently for approximately 6.5 months after a potential problem was identified by the pharmacist, there was the potential R61 had received one or both medications unnecessarily.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45410 Based on interview and record review, the facility failed to maintain complete and accurate medical records for 2 residents (Resident #33 and #61) of 19 residents reviewed for accuracy of medical records, resulting in the potential for miscommunication and an unclear picture of the resident's health care status. Findings include: Resident #33 Review of an Admission Record revealed Resident #33 admitted to the facility on [DATE] with pertinent diagnoses which included a foot ulcer, a pressure ulcer, and peripheral vascular disease. Review of a Minimum Data Set (MDS) assessment for Resident #33, with a reference date of 4/24/2024 revealed a Brief Interview for Mental Status (BIMS) score of 13, out of a total possible score of 15, which indicated Resident #33 was cognitively intact. Review of a current skin management Care Plan intervention for Resident #33, with a revision date of 12/22/2023, directed staff that Resident #33 used a right foam boot when in bed to aid in pressure reduction and possible friction. Review of Resident #33's Physician's Orders, active 6/26/2024, revealed .Apply foam boot while in bed to offload pressure and prevent friction from rubbing . Review of Resident #33's June Treatment Administration Record revealed frequent documentation of right foot foam boot use while in bed, including documentation of the foam boot being applied by LPN A on day shift and the evening shift of 6/25/2024. In an observation and interview on 6/26/2024 at 9:42 AM in Resident #33's room, LPN A was unable to find Resident #33's foam protective boot. LPN A reported was not sure when she had last seen the foam protective boot, but it had been at least a few weeks prior. LPN A found a black post op shoe in Resident #33's room and reported Resident #33 had worn this in bed on 6/25/2024 instead of the foam protective boot. LPN A reviewed Resident #33's orders and reported the post op shoe was to be worn when not in bed and the foam protective boot was to be worn while in bed according to current orders. LPN A reported she documented Resident #33 wearing the foam protective boot on 6/25/2024 in error. In an interview on 6/26/2024 at 11:58 AM, Competency Evaluated Nursing Assistant (CENA) E reported she had not seen Resident #33's foam protective boot in her room since early June. In an interview on 6/26/2024 at 12:03 PM, Regional Clinical Director C reported documentation should accurately reflect current treatment given. (continued on next page)

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	235384	A. Building B. Wing	06/26/2024

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Schnepp Senior Care and Rehab Center	427 E Washington Saint Louis, MI 48880

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of facility policy/procedure Medical Records, revised 7/15/2015, revealed .Provides guidelines for the maintenance of complete, and accurate record of each residents care from initial admission to final discharge . 30120 R61 A review of R61's Admission Record, dated 6/26/24, revealed R61 was a [AGE] year-old resident admitted to the facility on [DATE]. In addition, R61's Admission Record revealed multiple diagnoses that include right hip pain, chronic atrial fibrillation (an irregular fast heart rate), hypertension, and a history of transient ischemic attack (TIA- a mini-stroke)) and cerebral infarction (CI- a stroke). A review of R61's Pharmacy Recommendation, dated 12/7/23, revealed, PHARMACIST RECOMMENDS:: PHYSICIAN RECOMMENDATION: This resident is receiving Mobic (a non-steroidal anti-inflammatory (NSAID) used for pain)15 mg (milligrams) QD (once a day) and receives Eliquis (an anticoagulant- blood thinner- used to prevent blood clots in residents with a history of and/or at risk for strokes and atrial fibrillation) 5 mg BID (twice a day). Please be aware of the following black box warning: Cardiovascular events: [U.S. Boxed Warning]: NSAIDs are associated with an increased risk of adverse cardiovascular events, including MI (myocardial infarction- a heart attack), stroke, and new onset or worsening of pre-existing hypertension. Risk may be increased with duration of use or pre-existing cardiovascular risk factors or disease. Carefully evaluate individual cardiovascular risk profiles prior to prescribing. Use caution with fluid retention, CHF (congestive heart failure), or hypertension . Gastrointestinal (GI) events: [U.S. Boxed Warning]: NSAIDs may increase risk of gastrointestinal irritation, ulceration, bleeding, and perforation. These events may occur at any time during therapy and without warning. Use caution with a history of GI disease (bleeding or ulcers), concurrent therapy with aspirin, anticoagulants and/or corticosteroids, smoking, use of alcohol, the elderly or debilitated patients. Use the lowest effective dose for the shortest duration of time, consistent with individual patient goals, to reduce risk of GI adverse events; alternate therapies should be considered for patients at high risk. Please evaluate current therapy and indicate below the appropriate option for this resident. A review of R61's Pharmacy Recommendation, dated 12/12/23, revealed, PHARMACIST RECOMMENDS:: PHARMACIST RECOMMENDS:: PHYSICIAN RECOMMENDATION . (x) A benefit/risk analysis of current therapy warrants continuation at the present dose. Other treatment options have been attempted and this medication improves the quality of this resident's life. The benefits outweigh the risks . RESPONSE TO RECOMMENDATION: no changes to current medication . A review of R61's electronic medical record (EMR), dated 12/7/23 to 6/26/24, failed to reveal a benefit/risk analysis by the Medical Director (MD) G (R61's physician) for the concurrent (combined) use of Mobic and Eliquis. In addition, R61's EMR failed to reveal any documentation by MD G, and/or physician designee (e.g., a nurse practitioner, physician assistant, another physician) (e.g., a progress note or physician note), that MD G was aware of the pharmacy recommendation. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235384	A. Building B. Wing	06/26/2024

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/26/24 at 11:53 AM, the Director of Nursing (DON) stated R61's benefit/risk analysis for Mobic and Eliquis by MD G should be in the Misc (miscellaneous) section of R61's EMR. The surveyor notified the DON that the benefit/risk analysis could not be found in R61's EMR under the Misc section or any other section of R61's EMR. The DON stated she would look and see if she can find it. The surveyor requested a copy of R61's benefit/risk analysis, if it could be found, and the DON verbalized understanding. During a second interview on 6/26/24 at 02:55 PM, the DON stated there was not a benefit/risk analysis done by MD G, or any other physician/physician designee, in R61's EMR. She also stated she could not find a physician's note that indicated MD G addressed the concurrent use of Mobic and Eliquis in R61's EMR. As of the time of the conclusion of the survey and exit from the facility on 4/26/24 at 4:15 PM, the facility failed to provide any documentation that MD G had completed a benefit/risk analysis and/or addressed the concurrent use of Mobic and Eliquis. Clear, accurate, and accessible documentation is an essential element of safe, quality, evidence-based nursing practice . Documentation is sometimes viewed as burdensome and even as a distraction from patient care. High quality documentation, however, is a necessary and integral aspect of the work of registered nurses in all roles and settings . (ANA's (American Nursing Association) Principles for Nursing Documentation- Guidance for Registered Nurses, 2010, www.nursingworld.org, retrieved on 5/28/24). Timely documentation of the following types of information should be made and maintained in a patient's EHR (electronic health record- i.e., electronic medical record) to support the ability of the health care team to ensure informed decisions and high quality care in the continuity of patient care . Patient documentation frequently is used by professionals who are not directly involved with the patient's care. If patient documentation is not timely, accurate, accessible, complete, legible, readable, and standardized, it will interfere with the ability of those who were not involved in and are not familiar with the patient's care to use the documentation. (ANA's (American Nursing Association) Principles for Nursing Documentation- Guidance for Registered Nurses, 2010, www.nursingworld.org, retrieved on 5/28/24).