

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235625	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/30/2024
NAME OF PROVIDER OR SUPPLIER West Woods of Bridgman		STREET ADDRESS, CITY, STATE, ZIP CODE 9935 Red Arrow Hwy Bridgman, MI 49106	

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)
<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41424</p> <p>This citation pertains to intake: MI00143833</p> <p>Based on interview and record review the facility failed to ensure residents received care in accordance with professional standards of nursing practice to ensure accurate transcription of medications and monitoring of potentially dangerous medications in 1 of 2 residents (Resident #84) reviewed standards of practice, resulting in an overdose of blood thinner medication and potential bleeding.</p> <p>Findings include:</p> <p>Review of an Admission Record revealed Resident #100 was a male with pertinent diagnoses which included atrial fibrillation and high blood pressure.</p> <p>Review of current Care Plan for Resident #100, revised on 1/19/24, revealed the focus, .Potential with acute condition change with cardiopulmonary, metabolic, or infectious complications . (Resident #100) has a history of hypertension and atrial fibrillation . with the intervention .Review hospital discharge to determine baseline upon admission .Review of residents medication regime to identify a possible ADR (adverse drug reaction) .</p> <p>Review of current Care Plan for Resident #100, revised on 1/19/24, with the focus, .Potential risk for falls or injury related to: Thromboprophylaxis therapy (treatment that prevents blood clots from forming in the blood vessels), (Resident #100) has a history of falls in the community .</p> <p>Review of the facility transcribed Orders dated 1/19/24, revealed, .Warfarin 2.5 mg tablets .Take 1 tablet by mouth at bedtime for to prevent blood clots .Warfarin 1mg tablet, 2 tablets by mouth at bedtime for to prevent blood clots .</p> <p>Review of Telehealth Encounter dated 1/19/24 at 00:00 AM, revealed, .1/19/2024 00:00, revealed, .New Admission: Communication received regarding a new admission. Facility and medication orders have been reviewed and compared to discharge medication reconciliation, medications have been verified, and communication to nursing has been completed. Care team updated .Provider: (Nurse Practitioner (NP) O) . Addendum Details: 1/25/24 .Late entry: Reviewed hospital D/C medications over the phone with the nurse and the D/C summary was reviewed via fax . Note: This writer attempted to contact the admitting nurse practitioner with no return phone call prior to exit.</p> <p>(continued on next page)</p>

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
-----------------------------------------------------------------------	-------	-----------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235625	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/30/2024
NAME OF PROVIDER OR SUPPLIER West Woods of Bridgman		STREET ADDRESS, CITY, STATE, ZIP CODE 9935 Red Arrow Hwy Bridgman, MI 49106	
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)		
<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 5/29/24 at 4:47 PM, Nurse Practitioner (NP) N reported she was in the building on 1/21/24 and was not there to see Resident #100 on the warfarin prescription as she reported the pharmacy completed the dosing of warfarin and everything relevant at admission would be faxed to the pharmacy. NP N reported she took for granted everything was done and did not pay attention to the warfarin orders as the pharmacy dosed and the discharge medication were reviewed by the nurse and admitting provider. NP N reported she would go in and do the physical assessment of the resident and determine their needs.</p> <p>Review of Hospital Physician Discharge Summary dated 1/19/24, revealed, .warfarin sodium 2.5 mg Oral Daily; Patient taking differently: Take 1 tablet by mouth 3 (three) times a week Sunday, Wednesday, Friday at 4pm 2 mg Oral Daily .Patient taking differently: Take 2 tablets by mouth 4 (four) times a week Monday, Tuesday, Thursday, Saturday at 4pm .</p> <p>Review of Interdisciplinary Documentation dated 1/22/24 at 11:00 AM, revealed, .(Family Member T) who wanted to share some concerns since (Resident #100)'s admission to (Facility) .(Family Member T) as concerned with medications that had been ordered .Would send the provider to discuss all medications administered and to answer any questions she may have .</p> <p>Review of Concern Form dated 1/22/24, submitted by Family Member T revealed, .What is your complaint about? .Care & oversight of (Resident #100) and medication regimen .Concerned with warfarin medication administration .</p> <p>In an interview on 5/30/24 at 10:07 AM, Licensed Practical Nurse (LPN) M reported for the admission process the nurse would receive the packet of information from the attendants who brought the resident from the hospital, sometimes would get a call from the hospital nurse to give report on the resident, which would have the orders and past medical history information.</p> <p>In an interview on 5/30/24 at 12:34 PM, Clinical Care Coordinator (CCC) D reported an admission was a multiple nurse process, the second nurse verified the medications with the discharge summary with the medication list in the computer. Typically, orders were reviewed by the next shift nurse. The third check was completed by her, DON (Director of Nursing) or the next shift. During the week would be the DON or CCC. CCC D reported there was an admission checklist for the nurses to complete and it would be checked off by the second and third nurse who checked the medications. CCC D reported this was the only place the checks of medications were documented. Those checklists were not kept as they were an internal document.</p> <p>In an interview on 5/30/24 at 12:5 PM, Licensed Practical Nurse (LPN) F reported the facility used an admission checklist for admissions. LPN F reported the nurses worked together to complete a new admission most times. When orders were entered, there were triple checks of the accuracy of the orders. Usually, the second check was completed by the nurse who worked that evening, and the third check was completed by the clinical care coordinators (CCCs), on Monday if a weekend entry. LPN F reported the checklist, medications and other pertinent information was placed in a purple folder for the CCCs to review.</p> <p>In an interview on 5/30/24 at 4:39 PM, LPN G reported during admission if there were inconsistent orders, the nurse would contact the doctor at the hospital and contact the facility provider as well to let them know and seek direction on how to proceed.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235625	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/30/2024
NAME OF PROVIDER OR SUPPLIER West Woods of Bridgman		STREET ADDRESS, CITY, STATE, ZIP CODE 9935 Red Arrow Hwy Bridgman, MI 49106	

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)
<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 5/30/24 at 10:05 AM, Clinical Support, RN (CS) C reported for Resident #100 the nurse did not send to pharmacy the orders for an INR when entered medications and forwarded to pharmacy for dosing review. CS C reported the primary nurse practitioner did not review the medications as close as she should've and when she saw the resident on 1/21/24, she should have ordered an INR to be done. The order for pharmacy to dose coumadin didn't get entered until CCC D did it on 1/21/24 when she did her admission review.</p> <p>Review of the Fundamentals of Nursing revealed, Patient care requires effective communication among members of the health care team. The medical record is an important means of communication because it is a confidential, permanent, legal documentation of information relevant to a patient's health care. The record is a continuing account of a patient's health care status and is available to all members of the health care team. [NAME], [NAME] A.; [NAME], [NAME] Griffin; Stockert, [NAME]; Hall, [NAME]. Fundamentals of Nursing - E-Book (Kindle Locations 24088-24091). Elsevier Health Sciences. Kindle Edition.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235625	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/30/2024
NAME OF PROVIDER OR SUPPLIER West Woods of Bridgman		STREET ADDRESS, CITY, STATE, ZIP CODE 9935 Red Arrow Hwy Bridgman, MI 49106	
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)		
<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are free from significant medication errors.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41424</p> <p>This citation pertains to intake MI00143833</p> <p>Based on interview and record review, the facility failed to ensure medications were administered at the correct dose per the physician's order for 1 of 2 residents (Resident #100) reviewed for significant medication errors, resulting in the potential for adverse effects of an overdose of an anticoagulant medication.</p> <p>Findings include:</p> <p>Review of Intake dated 4/9/24, revealed, .However, the much greater concern is that this facility did not follow the prescribing instructions provided to them by (Local Hospital) for dosing (Resident #100)'s Warfarin and overdosed him causing him to have to be transported by Ambulance, put through additional examinations and tests, unknown physical damage, by having his blood way too thin. In addition, the facility and medical professionals did not follow standard protocol for Warfarin overdosing and were extremely slow to respond to this overdose when brought to their attention .</p> <p>Review of an Admission Record revealed Resident #100 was a male with pertinent diagnoses which included atrial fibrillation and high blood pressure.</p> <p>Review of current Care Plan for Resident #100, revised on 1/19/24, revealed the focus, .Potential with acute condition change with cardiopulmonary, metabolic, or infectious complications .(Resident #100) has a history of hypertension and atrial fibrillation . with the intervention .Review hospital discharge to determine baseline upon admission .Review of residents medication regime to identify a possible ADR (adverse drug reaction) .</p> <p>Review of current Care Plan for Resident #100, revised on 1/19/24, with the focus, .Potential risk for falls or injury related to: Thromboprophylaxis therapy (treatment that prevents blood clots from forming in the blood vessels), (Resident #100) has a history of falls in the community .</p> <p>Review of Physician Discharge Summary from (Local hospital) dated 1/19/24, revealed, .warfarin sodium 2.5 mg Oral Daily; Patient taking differently: Take 1 tablet by mouth 3 (three) times a week Sunday, Wednesday, Friday at 4pm 2 mg Oral Daily .Patient taking differently: Take 2 tablets by mouth 4 (four) times a week Monday, Tuesday, Thursday, Saturday at 4pm .</p> <p>Review of facility transcribed Orders dated 1/19/24, revealed, .Warfarin 2.5 mg tablets .Take 1 tablet by mouth at bedtime for to prevent blood clots .Warfarin 1mg tablet, 2 tablets by mouth at bedtime for to prevent blood clots .</p> <p>Coumadin (Warfarin Sodium) is a narrow therapeutic range drug and anticoagulation must be carefully monitored during Coumadin therapy. Adjust the Warfarin dose to maintain a typical target INR of 2.5 for deep vein thrombosis, pulmonary embolism and atrial fibrillation with an INR range of 2.0-3.0 for all treatment durations. (Bristol-[NAME] Squibb Company, [NAME], New Jersey, October 2011)</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235625	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/30/2024
NAME OF PROVIDER OR SUPPLIER West Woods of Bridgman		STREET ADDRESS, CITY, STATE, ZIP CODE 9935 Red Arrow Hwy Bridgman, MI 49106	
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)		
<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Telehealth Encounter dated 1/19/24 at 00:00 AM, revealed, .1/19/2024 00:00, revealed, .New Admission: Communication received regarding a new admission. Facility and medication orders have been reviewed and compared to discharge medication reconciliation, medications have been verified, and communication to nursing has been completed. Care team updated .Provider: (Nurse Practitioner (NP) O) . Addendum Details: 1/25/24 .Late entry: Reviewed hospital D/C medications over the phone with the nurse and the D/C summary was reviewed via fax . Note: This writer attempted to contact the admitting nurse practitioner with no return phone call prior to exit.</p> <p>Review of Medication Administration Record (MAR) for January 2024, revealed, Resident #100 was administered at 08:00 PM, 2mg by mouth at bedtime for to prevent blood clots on 1/19/24, 1/20/24, 1/21/24 . 2.5 mg by mouth at bedtime for to prevent blood clots on 1/19/24, 1/20/24, 1/21/24 . This inciated Resident #100 received 4.5mg Coumadin daily instead of the 2mg or 2.5mg's ordered by the discharge physician.</p> <p>In an interview on 5/29/24 at 4:47 PM, Nurse Practitioner (NP) N reported she was in the building on 1/21/24 and was not there to see Resident #100 on the warfarin prescription as she reported the pharmacy completed the dosing of warfarin and everything relevant at admission would be faxed to the pharmacy. NP N reported she took for granted everything was done, and did not pay attention to the warfarin orders.</p> <p>Review of Interdisciplinary Documentation dated 1/22/24 at 11:00 AM, revealed, .(Family Member T) who wanted to share some concerns since (Resident #100)'s admission to (Facility) .(Family Member T) as concerned with medications that had been ordered .Would send the provider to discuss all medications administered and to answer any questions she may have .</p> <p>Review of Concern Form dated 1/22/24, submitted by Family Member T revealed, .What is your complaint about? .Care & oversight of (Resident #100) and medication regimen .Concerned with warfarin medication administration .</p> <p>Review of (Name of Laboratory) results dated 1/22/24, revealed, .Collected date & time: 1/22/24 00:28 .INR 8.19 (CH- critical high) .1. Oral Anticoagulant therapeutic range: 2.00 - 3.00 .Prothrombin time: 79.2 (CH-critical high) .Normal range: 9.6 - 12.2 . The laboratory document indicated the critical high results were reported to the facility on [DATE]. Note: Faxed to Pharmacy noted on results. Initialed on 1/23/24 by Nurse Practitioner (NP) N.</p> <p>According to Mayo Clinic, The prothrombin time test is a test to evaluate blood clotting .Prothrombin is a protein produced by your liver. It is one of many factors in your blood that help it to clot appropriately . https://www.mayoclinic.org/tests-procedures/prothrombin-time/about/pac-20384661</p> <p>Review of Warfarin Dosing Program: Pharmacy to Facility Communication document dated 1/24/24 at 11:25 AM, revealed, .Additional Comments: On 1/22/24 - Informed (RN K), to contact prescriber for VITAMIN K administration (Last Lab on 1/15 INR 2.4) .</p> <p>Review of Interdisciplinary Documentation dated 01/22/2024 at 5:08 PM, revealed, .Received lab results via fax. INR was critical at 8.19. Results faxed to pharmacy. Received a call from pharmacist with order to draw INR tomorrow, hold coumadin pending result, and call provider to ask if they want to order vitamin k .</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235625	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/30/2024
NAME OF PROVIDER OR SUPPLIER West Woods of Bridgman		STREET ADDRESS, CITY, STATE, ZIP CODE 9935 Red Arrow Hwy Bridgman, MI 49106	
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)		
<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 5/20/24 at 11:15 AM, Registered Nurse (RN) K reported she saw the fax come in (1/22/24) and it was critical, and she faxed the results to pharmacy. When pharmacy called she was the one who answered the phone and got those recommendations from pharmacy for dosing the coumadin and to contact the provider if they wanted Vitamin K administered. RN K reported relayed the information to the nurse assigned to Resident #100.</p> <p>Review of the medical record showed no conversation with the provider on the Critical lab result of 8.19 and how the provider wanted to proceed with the pharmacy recommendation. No progress note was entered the provider was contacted.</p> <p>Review of Interdisciplinary Documentation dated 1/23/24 at 10:12 AM, revealed, .(Local lab) was called regarding lab draw stat PT/INR. They will be here in four hours or less .</p> <p>Review of Orders dated 1/23/24, revealed, .PT/INR Stat .Verbal .</p> <p>Review of Interdisciplinary Documentation dated 1/23/24 at 5:01 PM, revealed, .Spoke with (Family Member T), Resident 100's daughter regarding concerns with medication orders .(Family Member T) stated she had a list of (Resident #100)'s medications and was confused that what we reviewed was not what she had stated was his medication regimen .</p> <p>Review of (Name of Lab Company) blood draw form indicated blood drawn on, .1/23/24 at 3:45 PM . Completion time: 4:00 PM .report given to (LPN E) .Notes: Arrived at 11:30 no tubes available, ordered tubes, will return when tubes arrive. Returned at 1545 (3:45 PM), labs drawn from L (left) .</p> <p>Review of (Local Hospital Lab) results revealed, .Results: Critical!! .INR 7.2. Specimen Collected: 01/23/24 3:53 PM .Last Resulted: 01/23/24 7:04 PM .</p> <p>Review of medical record for Resident #100 revealed no follow up on 1/23/24 of the Critical lab results.</p> <p>In an interview on 5/30/24 at 1:44 PM, Lab Testing Manager (LTM) S reported the laboratory hours of operation were 8:00AM to 6:30PM Monday -Friday. On Saturday and Sunday, hours of operation were 08:00AM to 12:30PM. LTM reported if the laboratory was unable to fulfill the request for a stat lab that would be completed by the local hospital. If the lab was unable to fulfill the order, the facility would be contacted and the nurse who cared for the resident would be informed the lab was unable to complete the stat order. LTM S reported the lab would not just cancel the request and not notify the nurse. If they were not able to get a stat lab in the AM, they would get to it in the PM. LTM S reported they were at the facility on 1/5/24, 1/8/24, 1/15/24, 1/22/24, and 1/25/24. If a stat lab was submitted, someone would be dispatched to complete the request. There was a log sheet for the lab and the requisition, the phlebotomist would get a copy to the lab with her sample. LTM S reported for any critical labs the facility would be contacted by phone.</p> <p>Review of faxed (Local Hospital Lab) resulted revealed, .1/24/24 Faxed to (Name of Pharmacy) 10A .</p> <p>Review of Interdisciplinary Documentation dated 1/24/24 at 10:09 AM, revealed, .Resident's PT/INR results from 1/23: 68.6/7.2, Faxed results to pharmacy for coumadin dosing .</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235625	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/30/2024
NAME OF PROVIDER OR SUPPLIER West Woods of Bridgman		STREET ADDRESS, CITY, STATE, ZIP CODE 9935 Red Arrow Hwy Bridgman, MI 49106	
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)		
<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Warfarin Dosing Program: Pharmacy to Facility Communication document dated 1/24/24 at 11:25 AM, revealed, .Current INR 7.2 on 1/23/2024 (lab delayed) .Warfarin Orders: Hold Dose Until Back Within the Range .PT/INR Order: Please schedule next INR on 1/24/24 - Daily . Note: Handwritten Sent to ER 1/24/24. Fax received by facility on 1/24/24 at 12:33 PM.</p> <p>Review of Interdisciplinary Documentation dated 1/24/24 at 12:04 PM, revealed, .Spoke with daughter upon her arrival to the facility .(Family Member T) expressed frustration regarding her dad, (Resident #100)'s INR and why Vitamin K was not administered .I would call our provider to inquire and I would let her know as soon as I had more information .Placed a call to (Name of Medical Doctor) gave a verbal order for vitamin K and stated to send the resident out to hospital for evaluation .</p> <p>Review of Orders dated 1/24/24, revealed, .hold coumadin until back in range and give vitamin K stst (sic) pt/inr today .</p> <p>Review of Orders dated 1/24/24, revealed, .Transport to (Local hospital) ER .</p> <p>Review of Interdisciplinary Documentation dated 1/24/24 at 12:50 PM, revealed, .Resident's pharmacy recommendation for vitamin K and labs redrawn on 1/24 and coumadin on hold until back in range. MD called order to give Vitamin K 5 mg and send to ER for evaluation now .</p> <p>Review of Interdisciplinary Documentation dated 1/24/24 at 1:06 PM, revealed, .Spoke with (Medical Doctor U) gave verbal order to give Vit K 5 mg sub q (under the skin injection) STAT and send out to ER due to unmanageable INR .</p> <p>Review of Interdisciplinary Documentation dated 1/24/24 at 1:33 PM, revealed, .family wanted him sent based on INR results of 7.8 .</p> <p>Review of ED Provider Notes dated 1/24/24 at 1:18 PM, revealed, .(Resident #100) presents for complaint of elevated INR .States the patient received [NAME] the dose of Coumadin over the weekend and his INR was 8.9. His INR was most recently 7.2 last night. He was not given any vitamin K until today, received just prior to the facility calling 911 .He did have a fall on Sunday .Discharge home with outpatient f.u. (follow up) .strict return precautions .Medications changes: Vitamin K 100 mcg oral daily for 5 days, starting Wed 1/24/24, until Mon. 1/29/24, normal .</p> <p>In an interview on 5/29/24 at 4:59 PM, Licensed Practical Nurse (LPN) E reported she worked every other weekend, for stat labs or critical labs like the PT INR results were sent to the pharmacy to review and make recommendations for the warfarin dosing. The pharmacy would call to let know sending over a fax for recommendations. Once the recommendations were received, the nurse would contact the doctor/provider to let them know what the results were for the lab.</p> <p>In an interview on 5/30/24 at 10:07 AM, Licensed Practical Nurse (LPN) M reported for the admission process the nurse would receive the packet of information from the attendants who brought the resident from the hospital, sometimes would get a call from the hospital nurse to give report on the resident, which would have the orders and past medical history information.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235625	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/30/2024
NAME OF PROVIDER OR SUPPLIER West Woods of Bridgman		STREET ADDRESS, CITY, STATE, ZIP CODE 9935 Red Arrow Hwy Bridgman, MI 49106	
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)		
<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 5/30/24 at 12:34 PM, Clinical Care Coordinator (CCC) D reported an admission was a multiple nurse process, the second nurse verified the medications with the discharge summary with the medication list in the computer. Typically, orders were reviewed by the next shift nurse. The third check was completed by her, DON (Director of Nursing) or the next shift. During the week would be the DON or CCC. CCC D reported there was an admission checklist for the nurses to complete and it would be checked off by the second and third nurse who checked the medications. CCC D reported this was the only place the checks of medications were documented.</p> <p>In an interview on 5/30/24 at 12:5 PM, Licensed Practical Nurse (LPN) F reported the facility used an admission checklist for admissions. LPN F reported the nurses worked together to complete a new admission most times. When orders were entered there were triple checks of the accuracy of the orders. Usually, the second check was completed by the nurse who worked that evening, and the third check was completed by the clinical care coordinators (CCCs), on Monday if a weekend entry. LPN F reported the checklist, medications and other pertinent information was placed in a purple folder for the CCCs to review. LPN F reported for coumadin Monday labs were usually ordered in the electronic medical record (EMR). LPN F reported pharmacy was the one to dose coumadin, send to the pharmacy via fax and note that they were sent. LPN F reported we usually dose it and order the labs and then the pharmacy takes it from there. LPN F reported if there was a critical lab result, faxed the results to pharmacy, and notified the provider. LPN F reported the faxed come on the weekends to the medication room fax, pharmacy calls and let facility know sent a fax, if not your resident, let your peer know there was a critical lab.</p> <p>In an interview on 5/30/24 at 10:42 AM, Pharmacist R reported when the pharmacy received the order, would ask if the INR was drawn and how long ago, obtained medication history, drug list at that point. We asked for medications to determine if there was anything that would interact and create fluctuations. For those on coumadin, we would recommend to have an INR drawn in a day or two even if the resident was a weekend admission. Pharmacist R reported clinical monitoring on a discharge summary would be the monitoring of the residents INR/PT.</p> <p>In an interview on 5/30/24 at 4:39 PM, LPN G reported during admission if there were inconsistent orders, the nurse would contact the doctor at the hospital and contact the facility provider as well to let them know and seek direction on how to proceed.</p> <p>In an interview on 5/30/24 at 10:05 AM, Clinical Support, RN (CS) C reported for Resident #100 the nurse did not send to pharmacy the orders for an INR when entered medications and forwarded to pharmacy for dosing review. CS C reported the primary nurse practitioner did not review the medications as close as she should've and when she saw the resident on 1/21/24, she should have ordered an INR to be done. The order for pharmacy to dose coumadin didn't get entered until CCC D did it on 1/21/24 when she did her admission review. CS C reported when the lab was drawn on 1/22/24 and it was resulted at 8.19 Critical, not sure why the provider was not contacted, and the recommendation of vitamin K to be administered not followed up on. Reviewed the lab results for 1/23/24, CS C reported an order to do an INR stat was entered and resulted at Critical at 7.2 and was unsure as to why the results were not faxed over on 1/23/24 and did not happen until 1/24/24, as the provider should have been contacted right when the results were received and taken care of immediately. The critical lab should have been addressed the day of the result as it could have had consequences for the resident.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235625	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/30/2024
NAME OF PROVIDER OR SUPPLIER West Woods of Bridgman		STREET ADDRESS, CITY, STATE, ZIP CODE 9935 Red Arrow Hwy Bridgman, MI 49106	

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)
<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of document submitted to this writer on 5/30/24, revealed, .Coumadin order education .When a resident is on Coumadin, they need routine PT/INR lab levels drawn and the dosing is managed by the pharmacy. There needs to be an order for the pharmacy to dose the Coumadin. Then the day the lab is to be drawn there needs to be an order for that day to do so, with supplementary documentation where the INR result will be recorded on the MAR before administration of the Coumadin on the lab day .This is an order that we have a template for already. Under orders, next to new order, there is a search bar, on that line type PT/INR and it will pop up, click on it and the order will open and you simply need to change the date at the bottom of the order for the day the lab is ordered for .</p> <p>Review of policy, Medication Monitoring received on 5/30/24, revealed, .Appropriate laboratory monitoring of all residents should be done to ensure optimal therapeutic outcomes., decrease the risk of adverse events .</p> <p>1. Laboratory monitoring is recommended during the medication regimen review to comply with manufacturer specifications, current standards of practice .3. Certain drugs (i.e. IV medications and Clozaril) require lab values be reviewed by the pharmacist prior to dispensing, and facility will provide laboratory information as requested by the pharmacy .</p>