

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  285289	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  07/24/2024
NAME OF PROVIDER OR SUPPLIER  Old Mill Rehabilitation (Omaha Tcu)		STREET ADDRESS, CITY, STATE, ZIP CODE  1131 Papillion Parkway Omaha, NE 68154	

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><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45484</b></p> <p>Licensure Reference Number 175 NAC 12-006.10(D)</p> <p>Based on record reviews and interviews, the facility failed to ensure that Resident 1 was free from significant medication errors. This affected 1 of 5 residents sampled for medication administration. The facility census was 33.</p> <p>Findings are:</p> <p>A record review of Resident 1's Admission Record printed 07/24/2024 revealed the resident was admitted to the facility on [DATE] and had diagnoses of respiratory failure, heart failure, atrial fibrillation (an irregular heartbeat that may lead to blood clots), venous insufficiency (a condition in which the veins have problems sending blood from the legs back to the heart), and the presence of a pacemaker (a small battery-operated device that helps the heart beat in a regular rhythm).</p> <p>A record review of Resident 1's Order Summary printed 07/24/2024 revealed the resident had orders for the following:</p> <p>Warfarin (an anticoagulant, or medication that helps prevent blood clots by making the blood clot more slowly) 5 milligrams (MG) by mouth once a day on Sundays, Mondays, Wednesdays, and Thursday; and</p> <p>Warfarin 7.5 MG by mouth once daily on Tuesdays, Thursdays, and Saturdays. Both orders had a start date of 07/17/2024.</p> <p>A review of a communication form dated 07/19/2024 for Resident 1 revealed the resident had an INR (International Normalized Ratio-a standardized lab value that measures how long it takes blood to clot) of 5.6. The form also listed the resident's warfarin orders and included the response of the Advance Practice Registered Nurse (APRN) to 1 hold (to hold a medication means to not administer it) warfarin and 2 INR Sunday 07/21/2024.</p> <p>A review of the National Library Of Medicine page on INR (<a href="https://www.ncbi.nlm.nih.gov/books/NBK507707/#:~:text=%5B8%5DFor%20patients%20who%20are,increase%20the%20risk%20of%20bleeding">https://www.ncbi.nlm.nih.gov/books/NBK507707/#:~:text=%5B8%5DFor%20patients%20who%20are,increase%20the%20risk%20of%20bleeding</a>) revealed the following:</p> <p>For patients who are on anticoagulant therapy, the therapeutic INR ranges between 2.0 to 3.0. INR levels above 4.9 are considered critical values and increase the risk of bleeding.</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
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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A record review of Resident 1's Medication Administration Record (MAR) revealed that the warfarin 5 MG dose was documented as given on Friday 07/19/2024 and as not administered on Sunday 07/21/2024. The warfarin 7.5 MG dose was documented as given on Saturday 07/20/2024. Further review revealed that both warfarin orders were placed on hold on 07/22/2024.</p> <p>A review of Resident 1's Progress Notes revealed a note from 07/21/2024 that stated the warfarin was held that date.</p> <p>A review of a communication form dated 07/21/2024 for Resident 1 revealed the resident had an INR of 8.0. Further review revealed the form was addressed by the APRN on 07/22/2024 with 1 hold warfarin and 2 INR Wednesday 07/24/2024.</p> <p>A review of the facility policy Medication Errors dated 01/08/2024 revealed:</p> <p>'Significant medication error' means one which causes the resident discomfort or jeopardizes his/her health and safety or causes harm.</p> <p>1. The facility shall ensure medications will be administered as follows:</p> <p>a. According to physician's orders.</p> <p>An interview on 07/23/2024 at 4:49 PM with the DON confirmed Resident 1 had a high INR on 07/19/2024, the APRN gave an order on 07/19/2024 to hold the medication and recheck the INR on 07/21/2024, and Resident 1 received doses of warfarin on 07/19/2024 and 07/20/2024 and should not have. The DON further confirmed that the INR drawn on 07/21/2024 was higher than on 07/19/2024.</p> <p>An interview on 07/23/2024 at 7:23 PM with Licensed Practical Nurse (LPN) A confirmed that giving the warfarin when the order was to hold it was a significant medication error because of how high the INR was on 07/19/2024 and how much higher the INR was on 07/21/2024.</p>		