

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  335583	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  02/27/2025
NAME OF PROVIDER OR SUPPLIER  Archcare at Providence Rest		STREET ADDRESS, CITY, STATE, ZIP CODE  3304 Waterbury Avenue Bronx, NY 10465	
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>39365</p> <p>Based on record review and interviews conducted during the abbreviated survey (NY00310625) the facility failed to ensure the resident was free of significant medication errors. This was evident for one (1) out of three (3) residents sampled (Resident #1). Specifically, on 02/10/2023, Medical Doctor #1 stated that they mistakenly scheduled medication four times a day instead of one time at bedtime for Resident #1. The Medical Doctor #1 ordered Warfarin Sodium (Coumadin, a blood thinner) three (3) milligram one tablet by mouth at bedtime for rapid heartbeats caused by poor blood flow. The Medical Doctor #1 entered the times that the medication must be given at 07:30 AM, 12:00 PM, 5:30 PM and 9:00 PM. On 02/10/2023, Resident #1 was given two (2) doses, one (1) at 12:00 PM by Registered Nurse #1 and another dose at 9:00 PM by Registered Nursing #2. The Electronic Medication Administration Record dated 02/11/2023, documented Resident #1 was given three (3) doses of Warfarin Sodium at 7:30 AM, 12:00 PM, and 5:30 PM by Registered Nurse #3 instead on one (1) dose at bedtime. Resident #1's blood work was with normal range and there were no adverse reactions.</p> <p>The findings are:</p> <p>The facility Policy and Procedure titled Administration Frequency of Medication, reviewed 04/2022, documented the Physician will initiate the medication order and specify the administration frequency. If the physician wishes medication to be given at a time not in accordance with the administration schedule, the physician's orders must state a specific time. The nurse will transcribe medication orders onto the Medication Administration Record using the approved schedule.</p> <p>The facility Policy and Procedure titled Medication Administration, reviewed 08/2024, documented that the policy's purpose is to ensure that medications are administered according to Professional Standards of Practice. The medical record should be checked to clarify an order if there is a question. If still uncertain, the nurse should notify their immediate supervisor, physician, and vendor pharmacy. The medication should not be administered until the order is clarified.</p> <p>The facility's investigation dated 02/15/2023, documented that on 02/10/2023, the Medical Doctor changed Warfarin Sodium from 2.5 milligrams to 3 milligrams at bedtime, and according to the Medical Doctor, they entered the frequency incorrectly. Medical Doctor #1 entered the order into the Electronic Medical Record as bedtime and after meals. It resulted in Resident #1 receiving additional doses of Warfarin Sodium three milligrams. Resident #1 was assessed and monitored and did not have any adverse reactions. Medical Doctor #1 was verbally educated by the Medical Director. Registered Nurse #1 and Registered Nurse #3 were suspended and re-educated on medication administration.</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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 335583
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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>Resident #1 was admitted to the facility with a diagnosis of Atrial Fibrillation, Hypertension, and Dementia.</p> <p>The Minimum Data Set (an assessment tool) dated 01/14/2023, identified Resident #1 was severely impaired cognition.</p> <p>A Care Plan for Anticoagulant Therapy initiated 10/27/2022, documented intervention to administer anticoagulant as per the Medical Doctor's order.</p> <p>A Physician Order dated 02/10/2023 at 08:56 AM, documented Warfarin Sodium (Coumadin) three milligrams (one tablet) by mouth at bedtime for Paroxysmal Atrial Fibrillation. The Frequency was after meal and at bedtime. Times to be given: 07:30 AM, 12:00 PM, 5:30 PM, and 9:00 PM.</p> <p>A Medication Administration dated 02/10/2023, documented Warfarin Sodium three milligrams scheduled at 12:00 PM, was administered at 01:15 PM by Registered Nursing #1. Warfarin Sodium three milligrams scheduled at 05:30 PM, marked as not given by Registered Nursing #2. Warfarin three milligrams scheduled at 9:00 PM, was administered by Registered Nurse #2.</p> <p>A Medication Administration dated 02/11/2023, documented Warfarin Sodium three milligrams scheduled at 7:30 AM was given at 08:28 AM. Warfarin Sodium three milligrams scheduled at 12:00 PM, was given at 12:07 PM, and Warfarin Sodium three milligrams scheduled at 5:30 PM, was given at 5:00 PM and 12:00 PM by Registered Nurse #3.</p> <p>A Nursing Progress Note dated 02/11/2023 at 11:07 PM, documented Warfarin Sodium (Coumadin) three milligrams (one tablet) by mouth after meals and at bedtime on hold pending Medical Doctor clarification of the order. The on-call service number was called, and a message was left for Medical Doctor #1 to clarify the order. Registered Nurse Supervisor was informed. Warfarin was placed on hold until 6:00 PM on 02/12/2023.</p> <p>During a telephone interview on 02/13/2025 at 1:35 PM, Medical Doctor #1 stated it was an entry error on their part when they put an order in the Electronic Medical Record on 02/10/2023 for Warfarin Sodium three milligrams for Resident #1. Medical Doctor #1 stated that they mistakenly scheduled four times a day instead of one time at bedtime. Warfarin Sodium should be given once daily at bedtime, and there was no intention to give it four (4) times a day. Medical Doctor #1 stated the error was caught by the nurse the next day, and Resident #1 was monitored for bleeding with no adverse reaction noted. Labs were within therapeutic limits for residents on Warfarin Sodium International Normalized Ratio is between two to three. Medical Doctor #1 stated they and the staff closely monitored the International Normalized Ratio, and Warfarin Sodium was on hold and then resumed three milligrams at daily bedtime. Medical Doctor #1 further stated that the next day, the Medical Director discussed with them over the phone entering the orders in Electronic Medical Record and Warfarin Sodium medication.</p> <p>Registered Nurse #1's Written Statement dated 02/13/2023, documented that Registered Nurse #1 was a nurse on duty on 2/10/2023, and Resident #1 was assigned to them. Registered Nurse #1 stated they observed an order in the Electronic Medication Administration Record that Resident #1 was supposed to get Coumadin and they give Resident #1 Coumadin at 12:00 PM as ordered by the Physician and trusted what the doctor entered.</p> <p>(continued on next page)</p>		

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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>During a telephone interview on 02/13/2025 at 4:17 PM, Registered Nurse #2 stated they don't recall Resident #1 and don't recall any incident with Warfarin Sodium medication. Registered Nurse #2 stated they know that Warfarin Sodium (Coumadin) is given one time at bedtime.</p> <p>During a telephone interview on 02/27/2025 at 11:50 AM, Registered Nurse #3, who is no longer working in the facility, stated that they knew Warfarin Sodium should be given one time at bedtime and no more than 10 mg daily. Registered Nurse #3 stated they do not recall much detail about the incident because it was a while ago, but remember the order was entered wrong, but there were no prior notes or information that it was wrong. Registered Nurse #3 stated that sometimes, the doctor will adjust the dose or order additional doses. Registered Nurse #3 stated they saw the order that was due in the morning, and they administered it as per the doctor's orders in good faith that it was what the doctor ordered. Registered Nurse #3 stated they don't recall how many times they administered Warfarin Sodium on 02/11/2023. Registered Nurse #3 also stated that Resident #1 did not have an adverse outcome and was monitored for bleeding. Registered Nurse #3 stated that after the medication error was discovered, they were re-in-serviced on medication administration and on Warfarin Sodium.</p> <p>During an interview on 02/13/2023 at 3:16 PM, Registered Nurse Supervisor #1 stated that Licensed Practical Nurse #1 notified them on 02/11/2023 in the evening the order for Warfarin Sodium was off and question why Resident #1 would receive Warfarin Sodium multiple times. Registered Nurse Supervisor #1 stated they immediately checked the order and saw it was a mistake because Warfarin Sodium three milligram should be taken one time at bedtime instead of four times. Registered Nurse Supervisor #1 stated they called the Medical Doctor #1, and the order was placed on hold. Registered Nurse Supervisor #1 stated the labs were ordered to monitor the International Normalized Ratio and Prothrombin time. Registered Nurse Supervisor #1 stated Resident #1 was closely monitored, and there was no bleeding and no bruising. Registered Nurse Supervisor #1 stated all nurses who administer medications should know the medication specifics that it is standard of practice, and they are in-service on medication administration.</p> <p>During an interview on 02/14/2025 at 4:15 PM, the Director of Nursing stated that Registered Nurse Supervisor #1 notified them of a medication error, and an investigation was started immediately. The Director of Nursing stated the investigation revealed Medical Doctor #1 entered incorrect frequency for Warfarin Sodium three milligrams on 02/10/2023. The Director of Nursing stated they also discovered that Registered Nurse #1 gave a dose of Warfarin Sodium 3 milligrams on 02/10/2023 at 12:00 pm, saying they followed the doctor's orders. Registered Nurse #2 did not administer at 5:30 PM but gave it at 9:00 PM as it should be. Registered Nurse #2 did not inform anyone that they did not administer at 5:30 PM. The Director of Nursing stated that the following day, 02/11/2023, Registered Nurse #3 administered Warfarin Sodium at 7:30 AM, 12:00 PM, and 5:30 PM, also stating they were following the Medical Doctor's order. The Director of Nursing stated Physicians should be more careful and pay attention when they place an order using the order schedule set in the Electronic Medical Record. Medical Doctor #1 and other Medical Doctors were in-serviced by the Medical Director and had a meeting. The Director of Nursing stated it is standard of practice that Registered Nurses #1 and #3 should know if the order is not scheduled appropriately for a class of medication. They should have to hold medication, call the supervisor, and inform the Physician immediately.</p> <p>During an interview on 02/14/2025 at 4:45 PM, the Administrator stated that they were aware of the incident when Medical Doctor #1 made a mistake and ordered Warfarin Sodium four times a day instead of one time daily.</p> <p>(continued on next page)</p>		

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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>10 NYCRR 415.11(c)(3)(i)</p> <p>Based on the following corrective actions taken, on 03/23/2023, there was sufficient evidence that the facility corrected the noncompliance and was in substantial compliance with this specific regulatory requirement prior to and during the time of this survey.</p> <p>A Plan of Correction was not required for this citation.</p> <p>The facility took corrective actions and was found to be in substantial compliance prior to the surveyor's onsite visit on 02/13/2025.</p> <ol style="list-style-type: none"> <li>1. Warfarin Sodium three milligrams was immediately put on hold on 02/11/2023.</li> <li>2. Resident #1 was assessed by a Registered Nurse and Medical Doctor and monitored, and did not have any adverse reaction. Their International Normalized Ratio (a blood test that indicates how well the blood can clot) remained in the therapeutic range. Warfarin Sodium three (3) milligrams was resumed on 02/15/2023.</li> <li>3. Registered Nurse #1 and Registered Nurse #2 were removed from the schedule and did not return until they received education on 02/13/2023, regarding medication administration.</li> <li>4. The Policies on Medication Administration and Administration Frequency of Medication were reviewed.</li> <li>5. Facility provided in-service to all Registered Nurses and Licensed Practical Nurses. The Rights of Medication Administration on 02/13/2023 and Medication Coumadin on 02/13/2023 to 02/16/2023.</li> <li>6. Physician #1 was verbally educated by the Medical Director.</li> <li>7. Pharmacy Quality-Related Event related to medication error dated 02/15/2023.</li> <li>8. The pharmacy was advised to call the supervisor instead of security, and a designated supervisory phone number was provided to them to clarify all orders when there are questions.</li> <li>9. The facility performed Quality Assurance Performance Improvement Project Accuracy in time Documentation for Coumadin. Order Coumadin start dated 02/15/2023, completion date 08/15/2023</li> <li>10. Medical Meeting dated was hold 03/23/2023 to discuss and ensure medications are documented correctly.</li> <li>11. Audits for Coumadin results dated from 02/15/2023 to 07/26/2023.</li> <li>12. Interview with one Registered Nurse Supervisor, 3 Registered Nurses, 2 Licensed Practical Nurses revealed that the staff was knowledgeable about the Medication Administration Policy and Medication Warfarin Sodium therapy.</li> </ol>