| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 365346 | A. Building<br>B. Wing | 05/19/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Otterbein Lebanon Retirement Community | 585 North State Route 741<br>Lebanon, OH 45036 |

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<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure each resident's drug regimen must be free from unnecessary drugs.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, hospital record review, interviews, and review of the medication reference the facility failed to discontinue laboratory testing, per physician order, resulting in a resident receiving two anticoagulant medications concurrently. This affected one (Resident #92) of three residents reviewed for physician orders. The facility census was 142.<br><br>Findings include:<br><br>Review of the medical record revealed Resident #92 was admitted to the facility on [DATE] with diagnoses of atrial fibrillation, congestive heart failure, type II diabetes mellitus, and chronic kidney disease, stage III.<br><br>Review of the Medicare five-day Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #92 had intact cognition and was always incontinent of bowel and frequently incontinent of bladder. The resident required supervision with eating, moderate assistance with oral hygiene, maximal assistance with bathing, bed mobility and transfers and was dependent for personal hygiene, toileting and dressing.<br><br>Review of the plan of care dated 11/27/23 revealed Resident #92 had a focus area for anticoagulant therapy for the management of atrial fibrillation, which placed the resident at risk for bruising and/or bleeding. The goal was for Resident #92 was to be free from discomfort or adverse reactions related to anticoagulant use.<br><br>Review of the physician orders revealed Resident #92 had been on Warfarin (an anticoagulant) since admission to the facility on [DATE] with multiple dosage changes from admission to current. The most current orders for Warfarin dated 02/17/25 were for Warfarin 2 milligram (mg), by mouth in the evening every Tuesday, Wednesday, Thursday, Saturday and Sunday and Warfarin 4 mg, by mouth in the evening every Monday and Friday.<br><br>Additionally, Resident #92 had an order dated 02/17/25 authored by the Medical Director to check the resident's international normalized ratio (INR), on day shift, every two weeks on Mondays and for results to be called to the coumadin clinic. An INR is a blood test that monitors how well a medication like Warfarin is working to thin the blood by providing a numerical value that reflects the blood's tendency to clot. A higher INR value indicates slower clotting. Resident #92's goal was to maintain an INR between 2 and 3.<br><br>(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 |
|---|---|---|

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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|---|---|
| F 0757<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of the nurse progress notes from 04/17/25 to 04/18/25 revealed Resident #92 went out to the hospital for a planned elective procedure in the A.M. of 04/17/25 and returned to the facility on [DATE] at approximately 2:00 P.M.<br><br>Review of post-surgical procedure hospital documents for Resident #92 dated 04/18/25 revealed orders to discontinue Warfarin 2 mg, in the evening every Tuesday, Wednesday, Thursday, Saturday and Sunday and to discontinue Warfarin 4 mg, in the evening every Monday and Friday. A new order was written for Resident #92 to start taking Eliquis (Apixaban) 2.5 mg, one tablet by mouth, two times a day.<br><br>Review of the facility physician orders written on 04/18/25 revealed the Warfarin 2 mg and 4 mg orders were discontinued and Eliquis 2.5 mg, one tablet twice a day was started.<br><br>Review of the medication administration records for April 2025 revealed Warfarin 2 mg by mouth in the evening every Tuesday, Wednesday, Thursday, Saturday and Sunday and Warfarin 4 mg by mouth in the evening every Monday and Friday were discontinued on 04/18/25 and Eliquis 2.5 mg, one tablet twice a day was started and administered as ordered from 04/19/25 through 04/30/25. Resident #92 had an INR checked on 04/28/25 with a result of 1.2.<br><br>Review of the nurse progress note dated 04/28/25 at 3:33 P.M. authored by LPN #415 revealed Resident #92's INR was 1.2. A message was left with the Coumadin Clinic pending return call.<br><br>Review of nursing progress note dated 04/28/25 and timed 6:02 P.M. authored by LPN #450 revealed a return call was received by the Coumadin Clinic and new orders were received for Warfarin 6 mg by mouth now, start Warfarin 4 mg by mouth on Monday, Wednesday and Friday and Warfarin 2 mg on Tuesday, Thursday, Saturday and Sunday. Resident #92's INR was ordered to be rechecked in one week on 05/05/25. The resident and the medication administration record were updated with new orders.<br><br>Review of the medication administration record for April revealed Resident #92 did not receive the one-time dose of Warfarin 6 mg as ordered on 04/28/25.<br><br>Review of the May 2025 medication administration record revealed Resident #92 received Warfarin 2 mg on 05/01/25, 05/03/25 and 05/04/25, Warfarin 4 mg on 05/02/25 and 05/05/25 and Eliquis 2.5 mg twice daily from 05/01/25 through 05/06/25 as ordered. Review of the medication administration notes, when each dose of the Warfarin and Eliquis was administered a drug protocol warning triggered, indicating a possible drug to drug interaction was identified.<br><br>Review of INR testing results for Resident #92 revealed on 05/06/25 the resident had an INR of 4.5.<br><br>Review of the nurse's progress note dated 05/06/25 at 11:10 A.M. authored by Registered Nurse (RN) #310 revealed the INR result of 4.5 was called to the Coumadin Clinic and the clinic was notified by RN #310 that Resident #92 was receiving two anticoagulants, Warfarin and Eliquis, at the same time. Orders were received to discontinue the Warfarin and to monitor for signs and symptoms of bleeding. The facility medical director was also notified.<br><br>Further review of the nursing progress notes revealed on 05/06/25 at 3:56 P.M. the Medical Director gave an order to hold the Eliquis and recheck Resident #92's INR on 05/08/25; if the INR is between 2 and 3 the Eliquis may be restarted.<br><br>(continued on next page) |

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| F 0757<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of the INR test results from 05/08/25 revealed an INR of 2.4. Eliquis was restarted.<br><br>Phone interview on 05/15/25 at 2:44 P.M. with Registered Nurse (RN) #310 revealed on 05/06/25 she discovered Resident #92 was receiving two anticoagulants, Eliquis and Warfarin. Upon finding this, RN #310 initiated an incident report and made notifications to the Director of Nursing, the Assistant Director of Nursing #302, the cardiologist, the Medical Director, and Resident #92's family. RN #310 verified this should not have happened, stating when the Warfarin was discontinued on 04/18/25, the INR testing should have also been discontinued as Eliquis does not require INR testing. RN #310 stated, Resident #92 did not require additional medical treatment and did not experience any negative outcome.<br><br>Phone interview on 05/15/25 at 4:47 P.M. with the Medical Director verified the 04/28/25 order to restart the Warfarin came from the Coumadin Clinic, the same clinic that ordered the Eliquis on 04/18/25, after the elective surgical procedure on 04/18/25. The Medical Director revealed after investigating the root cause of the situation that led to Resident #92 being prescribed both Eliquis and Warfarin was the result of Resident #92 having blood drawn to test an INR level on 04/28/25, and the facility calling the results to the Coumadin Clinic. Since the INR result was 1.2 and below the 2 to 3 range wanted, the Coumadin Clinic ordered Warfarin to be restarted. The Medical Director verified that Eliquis does not require INR testing.<br><br>Phone interview on 05/16/25 at 11:37 A.M. with the hospital Electrophysiology Registered Nurse (EPRN) #155 verified the clinic had a current medication list for Resident #92 and the medication list should have been checked when the INR results were called in on 04/28/25. EPRN #155 verified the clinic's records showed that on 04/17/25 the resident's Coumadin was discontinued and Eliquis 2.5 mg, one tablet by mouth two times a day, was started. EPRN #155 verified the facility had no reason to perform INR testing when the resident was only receiving Eliquis.<br><br>Interview on 05/16/25 at 2:45 P.M. with the Director of Nursing (Administrator also present) revealed as part of the daily clinical meeting process progress notes and physician orders for the previous 24 hours and on Mondays for the previous 72 hours are reviewed. The Director of Nursing verified the facility failed to review the 04/28/25 order for Warfarin (Coumadin) because she was on vacation that week. She also verified Eliquis does not require INR testing.<br><br>Review of Medscape revealed the drug interaction between Eliquis and Warfarin was identified as serious and to use an alternative. Eliquis increases the effects of Warfarin by anticoagulation. Avoid combined use once INR is established in the desired therapeutic range.<br><br>This deficiency represents non-compliance investigated under Complaint Number OH00165551. |

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|---|---|
| F 0760<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that residents are free from significant medication errors.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, interviews and policy review, the facility failed to prevent a resident from receiving two anticoagulant medications concurrently resulting in a significant medication error. This affected one (Resident #92) of three residents reviewed for anticoagulant therapy. The facility identified 30 residents receiving anticoagulant medications. The facility census was 142.<br><br>Findings include:<br><br>Review of the medical record revealed Resident #92 was admitted to the facility on [DATE] with diagnoses of atrial fibrillation, congestive heart failure, type II diabetes mellitus, and chronic kidney disease, stage III.<br><br>Review of the Medicare five-day Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #92 had intact cognition and was always incontinent of bowel and frequently incontinent of bladder. The resident required supervision with eating, moderate assistance with oral hygiene, maximal assistance with bathing, bed mobility and transfers and was dependent for personal hygiene, toileting and dressing.<br><br>Review of the plan of care dated 11/27/23 revealed Resident #92 had a focus area for anticoagulant therapy for the management of atrial fibrillation, which placed the resident at risk for bruising and/or bleeding. The goal was for Resident #92 was to be free from discomfort or adverse reactions related to anticoagulant use.<br><br>Review of the physician orders revealed Resident #92 had been on Warfarin (an anticoagulant) since admission to the facility on [DATE] with multiple dosage changes from admission to current. The most current orders for Warfarin dated 02/17/25 were for Warfarin 2 milligram (mg), by mouth in the evening every Tuesday, Wednesday, Thursday, Saturday and Sunday and Warfarin 4 mg, by mouth in the evening every Monday and Friday.<br><br>Additionally, Resident #92 had an order dated 02/17/25 authored by the Medical Director to check the resident's international normalized ratio (INR), on day shift, every two weeks on Mondays and for results to be called to the Coumadin Clinic. An INR is a blood test that monitors how well a medication like Warfarin is working to thin the blood by providing a numerical value that reflects the blood's tendency to clot. A higher INR value indicates slower clotting. Resident #92's goal was to maintain an INR between 2 and 3.<br><br>Review of the nurse progress notes from 04/17/25 to 04/18/25 revealed Resident #92 went out to the hospital for a planned elective procedure in the A.M. of 04/17/25 and returned to the facility on [DATE] at approximately 2:00 P.M.<br><br>Review of post-surgical procedure hospital documents for Resident #92 dated 04/18/25 revealed orders to discontinue Warfarin 2 mg, in the evening every Tuesday, Wednesday, Thursday, Saturday and Sunday and to discontinue Warfarin 4 mg, in the evening every Monday and Friday. A new order was written for Resident #92 to start taking Eliquis (Apixaban) 2.5 mg, one tablet by mouth, two times a day.<br><br>(continued on next page) |

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| F 0760<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of the facility physician orders written on 04/18/25 revealed the Warfarin 2 mg and 4 mg orders were discontinued and Eliquis 2.5 mg, one tablet twice a day was started.<br><br>Review of the medication administration records for April 2025 revealed Warfarin 2 mg by mouth in the evening every Tuesday, Wednesday, Thursday, Saturday and Sunday and Warfarin 4 mg by mouth in the evening every Monday and Friday were discontinued on 04/18/25 and Eliquis 2.5 mg, one tablet twice a day was started and administered as ordered from 04/19/25 through 04/30/25. Resident #92 had an INR checked on 04/28/25 with a result of 1.2.<br><br>Review of the nurse progress note dated 04/28/25 at 3:33 P.M. authored by LPN #415 revealed Resident #92's INR was 1.2. A message was left with the Coumadin Clinic pending return call.<br><br>Review of nursing progress note dated 04/28/25 and timed 6:02 P.M. authored by LPN #450 revealed a return call was received by the Coumadin Clinic and new orders were received for Warfarin 6 mg by mouth now, start Warfarin 4 mg by mouth on Monday, Wednesday and Friday and Warfarin 2 mg on Tuesday, Thursday, Saturday and Sunday. Resident #92's INR was ordered to be rechecked in one week on 05/05/25. The resident and the medication administration record were updated with new orders.<br><br>Review of the medication administration record for April revealed Resident #92 did not receive the one-time dose of Warfarin 6 mg as ordered on 04/28/25.<br><br>Review of the May 2025 medication administration record revealed Resident #92 received Warfarin 2 mg on 05/01/25, 05/03/25 and 05/04/25, Warfarin 4 mg on 05/02/25 and 05/05/25 and Eliquis 2.5 mg twice daily from 05/01/25 through 05/06/25 as ordered. Review of the medication administration notes, when each dose of the Warfarin and Eliquis was administered a drug protocol warning triggered, indicating a possible drug to drug interaction was identified.<br><br>Review of INR testing results for Resident #92 revealed on 05/06/25 the resident had an INR of 4.5.<br><br>Review of the nurse's progress note dated 05/06/25 at 11:10 A.M. authored by Registered Nurse (RN) #310 revealed the INR result of 4.5 was called to the Coumadin Clinic and the clinic was notified by RN #310 that Resident #92 was receiving two anticoagulants, Warfarin and Eliquis, at the same time. Orders were received to discontinue the Warfarin and to monitor for signs and symptoms of bleeding. The facility medical director was also notified.<br><br>Further review of the nursing progress notes revealed on 05/06/25 at 3:56 P.M. the Medical Director gave an order to hold the Eliquis and recheck Resident #92's INR on 05/08/25; if the INR is between 2 and 3 the Eliquis may be restarted.<br><br>Review of the INR test results from 05/08/25 revealed an INR of 2.4. Eliquis was restarted.<br><br>(continued on next page) |

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|---|---|
| F 0760<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Phone interview on 05/15/25 at 2:44 P.M. with Registered Nurse (RN) #310 revealed on 05/06/25 she discovered Resident #92 was receiving two anticoagulants, Eliquis and Warfarin. Upon finding this, RN #310 initiated an incident report and made notifications to the Director of Nursing, the Assistant Director of Nursing #302, the cardiologist, the Medical Director, and Resident #92's family. RN #310 verified this should not have happened, stating when the Warfarin was discontinued on 04/18/25, the INR testing should have also been discontinued as Eliquis does not require INR testing. RN #310 stated, Resident #92 did not require additional medical treatment and did not experience any negative outcome.<br><br>Phone interview on 05/15/25 at 4:47 P.M. with the Medical Director verified the 04/28/25 order to restart the Warfarin came from the Coumadin Clinic, the same clinic that ordered the Eliquis on 04/18/25, after the elective surgical procedure on 04/18/25. The Medical Director revealed after investigating the root cause of the situation that led to Resident #92 being prescribed both Eliquis and Warfarin was the result of Resident #92 having blood drawn to test an INR level on 04/28/25, and the facility calling the results to the Coumadin Clinic. Since the INR result was 1.2 and below the 2 to 3 range wanted, the Coumadin Clinic ordered Warfarin to be restarted. The Medical Director verified that Eliquis does not require INR testing.<br><br>Phone interview on 05/15/25 at 5:23 P.M. with the Consulting Pharmacist with the Director of Nursing verified the pharmacy should have caught that Resident #92 was ordered two anticoagulants and further stated the pharmacy should not have sent two anticoagulants without speaking with the facility first for clarification.<br><br>Phone interview on 05/15/25 at 5:32 P.M. with the Pharmacy Manager and the Director of Nursing verified the Pharmacist who filled the 04/28/25 Warfarin order had knowledge Resident #92 was also on Eliquis and made a judgement to fill the order. The Pharmacy Manager verified the Pharmacist should have clarified with the facility before processing and sending the Warfarin prescription on 04/28/25. The Director of Nursing verified it would be the facility's responsibility to confirm the order with the physician, or in this case the Coumadin Clinic. The Director of Nursing verified the order and did trigger as a duplication error message, but because both medications were low doses the pharmacist went ahead and filled the 04/28/25 Warfarin prescription. The Pharmacy Manager revealed she would be consulted if the staff pharmacist had questions.<br><br>Phone interview on 05/16/25 at 11:12 A.M. with Coumadin Clinic Registered Nurse (CCRN) #150 revealed the clinic maintained an INR result flowsheet for Resident #92 and when results are called in from the facility it is documented on the flowsheet and the resident's current Warfarin order is verified. CCRN #150 was unable to explain how the Warfarin was ordered on 04/28/25 when the resident was already receiving Eliquis.<br><br>Phone interview on 05/16/25 at 11:37 A.M. with the hospital Electrophysiology Registered Nurse (EPRN) #155 verified the clinic had a current medication list for Resident #92 and the medication list should have been checked when the INR results were called in on 04/28/25. EPRN #155 verified the clinic's records showed that on 04/17/25 the resident's Warafin was discontinued and Eliquis 2.5 mg, one tablet by mouth two times a day, was started. EPRN #155 verified the facility had no reason to perform INR testing when the resident was only receiving Eliquis.<br><br>(continued on next page) |

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|---|---|
| F 0760<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Interview on 05/16/25 at 2:00 P.M. with Resident #92 revealed she had no recollection of being administered Warfarin and Eliquis simultaneously. The Resident verified she was feeling better after the elective procedure.<br><br>Interview on 05/16/25 at 2:45 P.M. with the Director of Nursing (Administrator also present) revealed as part of the daily clinical meeting process progress notes and physician orders for the previous 24 hours and on Mondays for the previous 72 hours are reviewed. The Director of Nursing verified the facility failed to review the 04/28/25 order for Warfarin because she was on vacation that week. She also verified Eliquis does not require INR testing.<br><br>Review of Medscape revealed the drug interaction between Eliquis and Warfarin was identified as serious and to use an alternative. Eliquis increases the effects of Warfarin by anticoagulation. Avoid combined use once INR is established in the desired therapeutic range.<br><br>Review of the policy titled, Medication Administration, revised 07/09/21, revealed medications will be administered to residents as prescribed and by persons lawfully authorized to do so in a manner consistent with good infection control and standards of practice. Personnel authorized to administer medications do so only after they have familiarized themselves with the medication. The facility has sufficient staff to allow administering of medications without unnecessary interruptions. The individual who administers the medication records the administration on the resident's Medication Administration Record directly after the medication is given.<br><br>This deficiency represents non-compliance investigated under Complaint Number OH00165551. |