STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366196	A. Building B. Wing	02/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Altercare Newark South Inc.	17 Forry Street Newark, OH 43055

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47987 Based on closed medical record review, hospital record review, facility policy review and interview, the facility failed to ensure Resident #44's physician was notified timely of missed consultation appointments and laboratory studies. This affected one resident (#44) of seven sampled residents. The facility census was 43. Findings include: Review of Resident #44's closed medical record revealed an admitted [DATE] with diagnoses including traumatic subdural hemorrhage without loss of consciousness, dysphagia, cerebral infarction, seizures, hypertension, atrial fibrillation and congestive heart failure. Resident #44 passed away in the facility on 01/11/25. Review of Resident #44's hospital discharge paperwork, dated 09/18/24, revealed Resident #44 was in the hospital from 09/12/24 until discharge to the facility on [DATE] due to a headache that was diagnosed as a spontaneous subdural hematoma due to a supratherapeutic International Normalized Ratio (INR) (a blood test that tells how long it takes for your blood to clot when on Coumadin (warfarin) level with her Coumadin on hold upon admission to the facility. The hospital records revealed Resident #44 was to follow with a cat scan (CT) (of her brain) and neurology after hospital discharge to resume her Coumadin. The neurology appointment was scheduled by the facility for 10/29/24. Review of a CT scan of the brain without contrast obtained 10/01/25 revealed extra-axial mixed attenuation fluid collection at the left cerebellum that was worrisome for chronic/subacute subdural hematoma. The medical record contained no evidence that the physician was notified of the CT results. Review of the progress note, dated 10/29/24 at 4:20 A.M. and authored by Licensed Practical Nurse #543, revealed the resident's pulse was in the 150's (meaning the pulse was between 150 to 159 beats per minute with the normal range being 60-90 beats per minute) and an order was given to send the resident out to the hospital. Review of Resident #44's hospital discharge documentation, dated 11/02/24, revealed the resident was admitted to the hospital with atrial fibrillation (abnormal heart rhythm pertaining to the atrium (top part) of the heart) with a rapid ventricular rate and congestive heart failure (CHF). She was discharged on [DATE], back to the facility. (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

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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Further review of the medical record revealed no evidence that the resident attended the follow-up neurology appointment due to her hospitalization (10/29/24 through 11/02/24) and the appointment was not rescheduled upon her return to the facility. Review of the 12/23/24 Minimum Data Set (MDS) revealed Resident #44 had a Brief Interview for Mental Status score of 15 out of 15 indicating the resident was cognitively intact. The assessment revealed the resident required supervision or touching assistance with transfers and ambulation and independent with all other aspects of care. The assessment also noted the resident received anti-coagulant medication. Review of the plan of care dated 01/02/25 for Resident #44 revealed the resident was at risk for bruising/bleeding related to use of potential side effect of medication: anti-coagulant with an intervention including obtain/report lab work per doctor order. Review of the physician's orders dated 01/02/25 revealed an order for an international normalized ratio (INR) (a blood test that tells you how long it takes for your blood to clot when on blood thinners, therapeutic ranges of INR results for a resident on an anticoagulation medication are 2.0 to 3.0 and levels become critical at 5.0) laboratory test to be completed every other day until INR was below three and the order was to be STAT with the scheduled time of 3:00 A.M. to 6:30 A.M. for draw time. Review of the medical record revealed no INR results were found for 01/06/25. Review of the progress notes dated 01/06/25 revealed no documented evidence the physician was notified of the laboratory testing not being completed on this date. On 02/06/25 at 12:21 P.M. an interview with the Director of Nursing (DON) revealed if laboratory tests were ordered as STAT, the physician should be notified by the end of the day if the laboratory result was not obtained for any reason and/or of the test results. On 02/06/25 at 1:28 P.M. interview with the Regional Nurse verified the physician was not notified on 01/06/25 of lab testing not being completed for Resident #44 due to insufficient specimen quantity. On 02/07/25 at 12:00 P.M. an interview with the DON revealed the DON believed Physician #300 was aware of the resident's CT scan results on 10/01/24 and that the resident missed her neurology appointment on 10/29/24 due to her hospitalization but verified neither notification was documented in the resident's medical record. On 02/07/25 at 9:23 A.M. interview with Physician #300 verified he was not aware the resident's labs were not completed on 01/06/25 until several weeks had passed. Review of the facility undated policy titled Anticoagulant Therapy Policy revealed physician notification was required for all abnormal lab results. This deficiency is based on incidental findings discovered during the course of this complaint investigation.

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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 0757 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47987 Based on closed medical record review, hospital record review, drug information review, review of the American Heart Association Journal at ahajournals.org, review of the facility policy Anticoagulant Therapy and interview, the facility failed to ensure anti-coagulant medication was monitored to ensure it was administered at a therapeutic dose and timely held in the presence of adverse consequences. This resulted in Immediate Jeopardy and actual harm beginning on [DATE] when Resident #44, who had a history of atrial fibrillation and an artificial heart valve managed with the anticoagulant medication, Coumadin (warfarin) and had been diagnosed and treated for a subdural hematoma prior to her admission to the facility, was ordered to resume her Coumadin at a higher dose than previously administered and without an ordered neurology consultation before resuming the anticoagulant medication. The facility failed to obtain physician ordered weekly International Normalized Ratio (INR) (a blood test that tells how long it takes for your blood to clot when on Coumadin (warfarin)) laboratory testing the weeks of [DATE], [DATE] and [DATE], to ensure the resident was receiving a therapeutic dose of Coumadin. On [DATE], Resident #44 developed a large bruise on her left buttock and sacrum. However, the facility did not identify this as a potential side effect of the anticoagulant medication. On [DATE], an INR was obtained, and the results were critical (high) at 17.2 seconds (normal anticoagulant range is two to three seconds). Physician #300 discontinued the dose of Coumadin and ordered the reversal agent, Vitamin K to be given and an INR every other day until the INR was less than three seconds. On [DATE], the resident's INR remained critical at 9.7 and the Vitamin K daily and INR every other day orders continued. There were no additional INR results available for review until [DATE] when the INR was subtherapeutic at 1.0 seconds. The physician ordered to resume Coumadin at two mg daily beginning [DATE]; however, the resident had experienced a significant decline in condition and was unable to take medications. The resident expired on [DATE]. This affected one Resident (#44) of seven residents sampled for injuries of unknown origin. The facility census was 43. On [DATE] at 3:20 P.M. the Administrator, Director of Nursing (DON) and Regional Nurse Consultant #201 were notified Immediate Jeopardy began on [DATE] when Resident #44 was started on Coumadin 5 milligrams (mg) without evidence the medication was safe to administer and that the dose was a therapeutic dose. Weekly INR testing was not completed between [DATE] and [DATE] as ordered. On [DATE] the resident was assessed to have significant bruising to her lower back/hip area (a likely side effect of Coumadin medication) without staff identifying the possibility of the supratherapeutic level. On [DATE], the resident's INR was critically high at 17.2 (therapeutic level 2XXX,d+[DATE].0 seconds when receiving Coumadin), requiring the administration of the Coumadin antidote, Vitamin K, to lower the resident's risk of hemorrhage. The facility failed to obtain additional testing on [DATE] or [DATE] as ordered. On [DATE] the resident's INR level was subtherapeutic at 1.0 seconds. At that time an order was obtained to resume the medication, Coumadin; however, the resident had a significant decline in her condition and was unable to swallow the Coumadin. The physician was not notified. The resident expired on [DATE]. The Immediate Jeopardy was removed on [DATE] when the facility implemented the following corrective actions: On [DATE] at 4:15 A.M. Resident #44 expired in the facility. (continued on next page)

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F 0757 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	On [DATE] at 12:05 P.M. to 12:15 P.M., Regional Nurse Consultant # 201 reviewed the records (including Coumadin orders, PT/INR, physician notification) for Resident #24, the only resident on Coumadin at the facility. As of [DATE] a plan was noted for Resident #24 to have laboratory testing (PT/INR) completed as ordered, PT/INR results reported within eight hours to the physician, signs and symptoms of elevated INRs (e.g. blood or black tarry stools, blood in sputum, emesis or urine, nose bleeds, bleeding gums and easy bruising or bleeding from wounds) identified and reported to the physician by a licensed nurse. On [DATE], in-service education for licensed nurses by the Director of Nursing (DON) via lecture began on the following topics: anticoagulation policy, signs and symptoms of bleeding related to Coumadin usage, lab policy, and change in resident condition or status which included abnormal labs. On [DATE] by 2:30 P.M. seven nurses (Licensed Practical Nurse (LPN) #133, LPN #104, LPN #125, LPN #130, LPN #108, Minimum Data Set (MDS) Nurse #106 and Assistant Director of Nursing (ADON) #123 were educated. The remaining four nurses (LPN #129, LPN #888, LPN #889 and Registered Nurse (RN) #109) would be educated before working their next scheduled shift. As of [DATE] the facility implemented a plan for all newly hired nurses to receive the education prior to working the floor. On [DATE] 3:00 P.M. the facility Lab Testing and Results policy was reviewed by the Executive Director and Director of Nursing. On [DATE] from 3:15 P.M. to 3:55 P.M., all 18 Certified Nursing Assistants (CNA) were educated by the DON via lecture on the signs and symptoms of bleeding that must be reported to the charge nurse. As of [DATE] the facility implemented a plan for all newly hired CNAs to receive the education prior to working the floor. On [DATE] at 4:00 P.M., MDS Nurse #106 completed a care plan review to ensure signs and symptoms of bleeding were addressed for residents receiving anti-coagulants. The facility identified and reviewed the care plan for 10 residents receiving anticoagulant medications (Resident #26, # 9, #24, #11, #32, #22, #29, #19, #28, and #4). Beginning [DATE], the Director of Nursing (DON) or designee would complete audits on all residents receiving Coumadin daily for two weeks, then three times a week for two weeks, then weekly for two weeks and then as needed to ensure PT/INR labs were obtained per order, notification to physician of PT/INR results were within eight hours and to ensure any signs and symptoms of bleeding were noted and reported to the physician as soon as practicable. Clinical findings and notifications will be documented in the clinical record. If the primary care physician is unable to be reached, the medical director will be notified. Beginning [DATE], the DON or designee would complete audits of five residents on anti-coagulant therapy three times a week for four weeks to ensure signs and symptoms of bleeding were addressed in the resident's care plan for residents receiving anti-coagulant medications. Any concerns identified with the audits will be forwarded to the Quality Assurance (QA) committee weekly for four weeks and as needed for immediate follow-up. The administrator will be responsible for ongoing compliance. (continued on next page)

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F 0757 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Interviews on [DATE] from 1:12 P.M. to 1:21 P.M. with ADON #123, CNA #1000, CNA #124, and LPN #125 revealed knowledge of the corrective actions. Although the Immediate Jeopardy was removed on [DATE], the facility remained out of compliance at a Severity Level 2 (no actual harm with potential for more than minimal harm that is not Immediate Jeopardy) as the facility was in the process of implementing their corrective action plan and monitoring to ensure on-going compliance. Findings include: Review of Resident #44's closed medical record revealed an admitted [DATE] with diagnoses including traumatic subdural hemorrhage without loss of consciousness (present on admission), dysphagia, cerebral infarction, seizures, hypertension, atrial fibrillation and congestive heart failure. The resident passed away in the facility on [DATE]. Review of Resident #44's hospital discharge paperwork, dated [DATE], revealed Resident #44 was in the hospital from [DATE] until discharge to the facility on [DATE] due to a headache that was diagnosed as a spontaneous subdural hematoma due to a supratherapeutic INR level with her Coumadin on hold upon admission to the facility. The resident was noted to be taking Coumadin two mg daily five days a week and Coumadin one mg daily, two days per week prior to her hospitalization . The hospital records revealed Resident #44 was to follow with a cat scan (CT) (of her brain) and neurology after hospital discharge to resume her Coumadin. The neurology appointment was scheduled by the facility for [DATE]. Review of a CT scan of the brain without contrast obtained [DATE] revealed extra-axial mixed attenuation fluid collection at the left cerebellum that was worrisome for chronic/subacute subdural hematoma. The medical record contained no evidence that the physician was notified of the CT results. Review of the progress note, dated [DATE] at 4:20 A.M. and authored by Licensed Practical Nurse #543, revealed the resident's pulse was in the 150's (meaning the pulse was between 150 to 159 beats per minute with the normal range being ,d+[DATE] beats per minute) and an order was given to send the resident out to the hospital. Review of Resident #44's hospital discharge documentation, dated [DATE], revealed the resident was admitted to the hospital with atrial fibrillation (abnormal heart rhythm pertaining to the atrium (top part) of the heart) with a rapid ventricular rate and congestive heart failure (CHF). She was discharged on [DATE], back to the facility and there were no instructions for the resident's Coumadin to be resumed at this time. Further review of the medical record revealed no evidence that the resident attended the follow-up neurology appointment due to her hospitalization ([DATE] through [DATE]) and the appointment was not rescheduled upon her return to the facility. Review of a physician order dated [DATE] revealed an order for Resident #44 to receive Morphine concentrate 20 milligrams (mg)/ milliliter (ml) with a dose of 5 mg orally every hour as needed for pain. (continued on next page)

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F 0757 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Review of a physician progress note, dated [DATE] and authored by Physician #300, revealed the resident would resume Coumadin at a later time with close monitoring due to (the resident) being high risk for a cerebral vascular accident secondary to a mechanical heart value. Further review of the progress note revealed the physician planned to resume the Coumadin 90 days after the resident's subdural hematoma/bleed. A review of a physician's order dated [DATE] revealed an order to admit Resident #44 to hospice services with the diagnosis of heart failure. Review of a physician progress note, dated [DATE] and authored by Physician #300, revealed the resident was to resume Coumadin with weekly INRs. Review of the physician's orders revealed an order for warfarin (Coumadin) five milligrams (mg) by mouth daily beginning on [DATE] for atrial fibrillation and the presence of a mechanical heart valve. A physician order was also noted (dated [DATE]) for an INR (laboratory testing) to be drawn every Wednesday with the first test to be completed on [DATE]. Review of the Medication Administration Record for [DATE] revealed the administration of Coumadin 5 mg during the 6:30P.M. to 10:30 P.M. time frame daily from [DATE] through [DATE]. Review of a social services note, dated [DATE] at 3:56 P.M. and authored by Social Services #137, revealed Resident #44 spoke about wanting to return home for a few days to see if she was able to care for herself. Social Service staff spoke with Physician #300, and he agreed to discharge the resident home for two days; however, he wanted hospice to be involved. Social Service staff also spoke with the resident's friend, who was her support system, regarding possible (leave of absence/discharge) arrangements. Review of a hospice notes dated [DATE] revealed Resident #44 was alert and oriented and ambulating to the bathroom with a walker and using Morphine for chronic back pain. The resident's physician agreed with the discharge. The facility made arrangements for home health and oxygen services. Review of a social service note, dated [DATE] at 10:16 A.M. and authored by Social Services #137, revealed the resident decided to cancel hospice services due to wanting to discharge home. A hospice patient notice of enrollment changes with the selection of I am seeking curative treatment which is not focused on comfort and palliation of symptoms for my terminal illness, signed by Resident #44, Social Services #137 and a hospice representative. Record review revealed no evidence the facility developed or implemented a plan of care related to Resident #44's anti-coagulant/Coumadin use and no nursing progress notes indicating the monitoring of side effects related to the Coumadin medication. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #44 had a Brief Interview for Mental Status score of 15 out of a possible 15 points, indicating the resident was cognitively intact. The assessment revealed the resident required supervision or touching assistance with transfers and ambulation and was continent of bladder and bowel. The resident required staff set up and/or was independent with other activities of daily living. The MDS included the resident received anti-coagulant medication. (continued on next page)

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F 0757 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Review of a social service note, dated [DATE] at 7:39 P.M. and authored by Social Services #137, revealed Resident #44 has successfully been attending physical therapy. The resident decided to return to her home on [DATE]. Review of the Certified Nursing Assistant point of care history (located in the electronic medical record) for Resident #44 revealed from [DATE] to [DATE] the resident experienced a decline in her activities of daily living as she was independent with rare, limited assistance then she began to require extensive and total assistance from staff. The resident was rarely incontinent of bladder and declined to frequently incontinent during her stay in the facility. Review of a progress note, dated [DATE] at 2:12 P.M. and authored by the DON, revealed Resident #44 had a skin abnormality. Resident #44 was interviewed by the DON on [DATE] and stated that she did not fall but it was possible that she sat down too hard on the toilet riser (an elevated toilet seat to aid in not having to reach low to sit on the toilet). Resident #44's physician was notified, and an x-ray was obtained of the resident's sacrum and coccyx with the results of the x-ray showing no bony abnormalities. Review of a social service note, dated [DATE] at 4:55 P.M. authored by Social Services #137, revealed the resident was to be discharged today, but she had developed a headache and pain from a bruise. Resident #44 also complained of no energy or being able to get out of bed to ambulate. She was very anxious about returning home and discussed her options with a revisit tomorrow on going home. (There was no further documentation in the medical record regarding the resident wanting to discharge home). Review of an Alteration in Skin Integrity form, dated [DATE] and authored by the DON, revealed it was marked as other: bruise and that an x-ray was completed with no fractures found. The human body illustration with the form had areas circled on the left buttock extending toward the left hip and the coccyx sacral area to indicate the placement of the bruising. There were no measurements of the bruise listed on the form. Review of the Medication Administration Record (MAR) dated [DATE] at 10:59 A.M. for Resident #44 revealed sacral pain rated an eight on a 0 to 10 pain scale with the administration of Morphine 20mg/ml give 5 mg orally with the results not effective. Further review revealed at 12:41 P.M. the resident continued to have sacral pain of an eight on a 0 to 10 pain scale with the administration of Morphine 5 mg. Review of a progress note, dated [DATE] at 2:17 A.M. and authored by LPN #133, revealed the resident's INR results were reported to the facility by the laboratory at a critical high level of 17.2 seconds. The physician was notified, and orders were received to hold the resident's Coumadin until the INR was below three and to give Vitamin K 10 mg one time and to have the INR done every other day beginning on [DATE] until the INR was below three. The note further revealed the Vitamin K was given and tolerated by Resident #44 and no bleeding was observed. The laboratory testing for the INR was collected on [DATE] at 12:31 P. M. and resulted at 4:57 P.M. Further review of Resident #44's physician's orders revealed an order for Vitamin K (medication administered to reverse the effects of Coumadin) 10 mg on [DATE] and then on [DATE] 10 mg daily until Resident #44's INR returned to below three. Resident #44's INR was to be checked every other day until the INR returned to below three. (continued on next page)

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F 0757 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Review of the MAR revealed on [DATE] at 4:42 P.M. the resident reported pain rated a seven out of 10 on a pain scale and Morphine 5 mg was administered. Review of the MAR dated [DATE] at 7:51 A.M. for Resident #44 revealed coccyx pain rated a seven on a 0 to 10 pain scale with Morphine 5 mg administered by the Assistant Director of Nursing. Review of the laboratory test result dated [DATE] revealed the INR result was 9.7 (a critically high level). Review of a progress note, dated [DATE] at 1:18 P.M. and authored by the DON, revealed the MD (physician) was notified of INR results and new orders were received. Review of Resident #44's physician orders dated [DATE] revealed an order for Vitamin K 10 mg daily at bedtime until INR below three. Review of the [DATE] MAR revealed the Vitamin K 10 mg was administered daily from [DATE] through [DATE] except on [DATE] due to medication delivery. Review of Resident #44's care plan dated [DATE] (the first care plan for the resident's increased potential for bleeding related to medication use) revealed the facility staff were to observe for and report any adverse effects such as easily bruising, unexplained bruising or bleeding, bloating/stomach pain or chest pain/tightness. Staff were also to observe for and report to the physician any signs of active bleeding such as nosebleed, bleeding gums, petechiae (are round, brown purple spots due to bleeding under the skin), purpura (a rash of purple spots due to small blood vessels leaking into the skin), ecchymosis (bruised) areas, hematoma, blood in urine, black/tarry stool, blood in sputum, elevated temp, pain in joints, abdominal pain, or coffee ground emesis. Further review revealed laboratory work was to be obtained as ordered and reported to the physician. Review of the MAR dated [DATE] at 4:23 A.M. for Resident #44 revealed back pain rated a six on a 0 to 10 pain scale with Morphine 5 mg oral administered with semi effectiveness. There was no documentation Physician #300 was notified of the resident's use of her as needed (prn) dose of Morphine currently being frequently used. Review of a physician's order dated [DATE] revealed a new order for Resident #44 for a hospice consult for overall decline in condition. There was no documentation in the medical record regarding the resident's decline other than she began to experience lower back pain and was placed on hospice services. Review of a hospice visit note, dated [DATE] and authored by Hospice Nurse #322, revealed Resident #44 was only alert to person, was bed/wheelchair bound and had bruising to back and coccyx area with scattered bruising, also noted bruising to her upper and lower extremities with pain rated a five on a 0 to 10 pain scale using the FLACC (Face, Legs, Activity, Cry and Consolability)(a pain scale used in children and non-verbal adults who cannot communicate their pain verbally) pain scale, undetermined location. (continued on next page)

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F 0757 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Review of a progress note, dated [DATE] at 12:21 P.M. and authored by Registered Nurse (RN) #777, revealed Resident #44's physician was notified the laboratory testing for the INR was not completed the day before. The physician discontinued the order for the [DATE] INR and ordered for the INR schedule to be resumed the next day as previously ordered ([DATE]). Review of a progress notes dated [DATE] revealed no mention the laboratory testing was not completed on this date and there was no documentation regarding follow-up with the lab or the physician regarding the scheduled INR. Review of the MAR dated [DATE] at 10:30 P.M. for Resident #44 revealed the resident complained of back pain rated a six on a 0 to 10 pain scale with Morphine 5 mg administered. Review of a physician progress note dated [DATE] revealed Resident #44's INR to be pending and to resume Coumadin when INR was less than 3.5 at two mg every day. Review of the INR results dated [DATE] revealed the resident's INR was 1.0 seconds (low/subtherapeutic) on this date. An order was received on [DATE] at 9:38 A.M. for Coumadin two mg daily. However, review of the MAR for [DATE] revealed the resident was unable to take the Coumadin on [DATE] and [DATE]. Review of the medical record revealed the resident was pronounced deceased by Physician #300 at 4:15 A. M on [DATE]. Review of the fax sheet from the contracted Laboratory Services, sent to the facility for Resident #44, revealed the INR lab was cancelled on [DATE] due to the specimen quantity not sufficient for testing. This fax was sent to the facility on [DATE] at 1:06 P.M. (and the only record of lab communication regarding this INR and why the lab was not completed. There was no evidence of facility follow-up regarding the missing lab until [DATE]). On [DATE] at 2:00 P.M. an interview with the DON revealed the bruising on Resident #44's left buttock extending toward the left hip and coccyx/sacral area was not measured (facility policy is to not measure bruises) but was of significant size. The DON further stated Resident #44, when questioned, did say that she might have sat down on the toilet riser in such a way as to hit the area causing the bruising. A follow-up interview with the DON on [DATE] at 9:00 A.M. revealed the facility had not completed the laboratory testing for Resident #44's INR as ordered on [DATE]. The INR testing was completed on [DATE] as a result of an audit for missing laboratory work (unrelated to Resident #44) completed by the facility and not because of the bruising on Resident #44's left buttock extending toward the left hip and coccyx sacral area that had been identified on [DATE]. The DON verified the facility had not identified the missing INR labs at the time of the resident's bruising and verified this bruising was not considered a possible side effect of the resident's Coumadin. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366196	A. Building B. Wing	02/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Altercare Newark South Inc.	17 Forry Street Newark, OH 43055

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F 0757 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	On [DATE] at 3:15 P.M. an interview with the DON revealed nurses who received orders to place residents on Coumadin medication were to place the order for laboratory monitoring in matrix care (the facility's electronic medical record system) and in the facility's electronic system for communicating with their laboratory provider (the laboratory order system). Nursing staff were expected to monitor residents on Coumadin for signs and symptoms of bleeding such as active bleeding, black tarry stools or abnormal bruising. If a resident on Coumadin had an unwitnessed fall or a fall where they hit their head the staff was to notify the DON and the physician, and the resident would be sent to the emergency room for evaluation. On [DATE] at 8:40 A.M. an interview with Physician #300 revealed the physician expected residents who were taking Coumadin to have weekly INR monitoring as ordered. Physician #300 stated he was aware of the bruising on Resident #44's left buttock extending toward the left hip and coccyx sacral area. Physician #300 further stated the bruising was most likely a result of the elevated INR. Physician #300 stated he did not know why the INR was so elevated but stated that he would like to think it would have been caught prior to reaching a critical high level if the INRs had been completed weekly as ordered. During the interview, Physician #300 stated at no time did the resident have any active bleeding. However, no additional information was provided as to how this determination was made. On [DATE] at 10:15 A.M. an interview with Certified Nursing Assistant (CNA) #138 revealed Resident #44 had a large bruise on her lower back below her waist. CNA #138 stated prior to the bruise being identified, Resident #44 would get up by herself with her walker and take herself to the bathroom. Resident #44's toilet was equipped with a toilet riser to elevate the toilet seat for the resident. CNA #138 stated Resident #44 would at times flop on to the toilet instead of using the safety bars to lower herself to the seat and she could have easily bumped the toilet riser if she flopped on to the toilet seat when by herself. On [DATE] at 1:28 P.M. an interview with RN #123 revealed the nurse who receives the order for Coumadin was responsible for entering the order into matrix care (the electronic medical record software) and enters the order for the laboratory testing/INR to be completed, usually weekly. The nurse working the night laboratory tests were to be drawn prints the log from the lab system and checks matrix care for laboratory test orders. It was the responsibility of the nurse who received the order to put the INR order in matrix care and the lab system. RN #123 stated nurses caring for a resident on Coumadin should watch for bruising, black tarry stools and any bleeding. On [DATE] at 12:00 P.M. an interview with the DON revealed the DON believed Physician #300 was aware of the resident's CT scan results on [DATE] and that the resident missed her neurology appointment on [DATE] due to her hospitalization but verified neither notification was documented in the resident's medical record. On [DATE] at 8:43 A.M. an interview with a nurse who wished to remain anonymous, revealed following admission to the facility, Resident #44 was always alert and oriented and self-ambulatory. The anonymous staff revealed the resident had experienced an obvious decline in condition in [DATE] after the nurse had been off work for a couple days. During this time period, the resident was no longer oriented as before, was bed bound and required staff assistance, which was not the resident's baseline. (continued on next page)

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F 0757 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	On [DATE] at 9:23 A.M. a follow-up interview with Physician #300 revealed he was not aware the resident was having extensive pain that required Morphine. The physician revealed when he ordered the hospice consultation on [DATE] it included a diagnosis of encephalopathy which he based on the resident's cognition level. Physician #300 revealed he was not aware of the resident's laboratory/INR testing not being completed until several weeks had passed and he did not think her condition warranted a hospital visit for an INR being over 17 as he did not believe the resident was actively bleeding. The physician indicated he treated the elevated INR level with Vitamin K. The physician also indicated he was aware the resident was still receiving Vitamin K daily as his order was to give until her INR was below three and he was never notified of her INR not being drawn for [DATE]. During the interview, Physician #300 revealed despite Resident #44 being new to his care upon her admission to the facility in [DATE], he believed administering Coumadin 5 mg daily with weekly INR testing was safe for the resident. However, the physician indicated his course of care would have changed if he had been notified of labs not being drawn appropriately or if the resident was having extensive pain. However, the physician stated he was not aware of this. No additional information was provided during interview regarding the CT scan results, the resident not attending the neurology appointment or if additional testing was considered or obtained when the INR was identified as supratherapeutic on [DATE]. On [DATE] at 1:01 P.M. information obtained via email from the Administrator revealed the resident's INR was not completed on [DATE] due to an inadequate amount of blood being obtained. The facility had been notified of this via telephone (the specimen could not be used); however, there was no documentation of the lab notification, so the facility had the lab fax the sheet over to show the reason the lab wasn't completed per order. Messages were left with the hospice provider for interview during the onsite survey; however, no return calls were received. Review of the undated facility Anticoagulant Therapy Policy revealed the facility was to make arrangements to have appropriate laboratory testing completed as ordered by the physician. Further review revealed the physician would be notified of any change in condition of the resident including bruising and bleeding. Review of undated Additional Drug Information for warfarin (Coumadin) available in the electronic medical record/the resident's electronic medication administration record (this is the information nurses have available related to the medications ordered and can use as a resource if needed) revealed side effects include but are not limited to intracerebral hemorrhage, hemorrhage and purpura (the collection of small blood pools under the skin). Label warning included immediately report bleeding or bruising to your doctor. (continued on next page)

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F 0757 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Review of the American Heart Association Journals at ahajournals.org dated [DATE] revealed Coumadin (warfarin) is a prescription medication used to prevent harmful blood clots from forming or growing larger. Beneficial blood clots prevent or stop bleeding, but harmful blood clots can cause a stroke, heart attack, deep vein thrombosis, or pulmonary embolism. Because warfarin interferes with the formation of blood clots, it is called an anticoagulant. Many people refer to anticoagulants as blood thinners; however, warfarin does not thin the blood but instead causes the blood to take longer to form a clot. The formation of a clot in the body is a complex process that involves multiple substances called clotting factors. Warfarin decreases the body's ability to form blood clots by blocking the formation of vitamin K-dependent clotting factors. Vitamin K is needed to make clotting factors and prevent bleeding. Therefore, by giving a medication that blocks the clotting factors, your body can stop harmful clots from forming and prevent clots from getting larger. It is important to monitor the INR (at least once a month and sometimes as often as twice weekly) to make sure that the level of warfarin remains in the effective range. If the INR is too low, blood clots will not be prevented, but if the INR is too high, there is an increased risk of bleeding. This is why those who take warfarin must have their blood tested so frequently. Unlike most medications that are administered as a fixed dose, warfarin dosing is adjusted according to the INR blood test results; therefore, the dose usually changes over time. This deficiency represents non-compliance investigated under Complaint Number OH00161229.