STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366472	A. Building B. Wing	11/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Capri Gardens	6975 Graphics Way Lewis Center, OH 43035

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 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48568 Based on closed medical record review, review of the hospital records, staff and physician interviews, review of facility letters, and review of the facility policy, the facility failed to ensure Resident #80's continuity of care from the hospital to the facility was thoroughly reviewed and implemented. This resulted in Immediate Jeopardy and the potential for serious life-threatening injuries, negative health outcomes and/or death on [DATE] when Resident #80 received Coumadin (anticoagulation medication) despite hospital orders and recommendations to stop anticoagulation therapy until seen by the neurosurgeon. Consequently, this resulted in Resident #80 being sent to the hospital and admitted to the neuro critical care unit on [DATE] due to an increased subdural hemorrhage (a collection of blood between the brain and the skull that can be life-threatening) and a craniotomy (a surgical procedure that involves removing a portion of the skull to access the brain) for subdural evacuation (a surgical procedure to remove subdural hematoma). This affected one (Resident #80) of four residents reviewed for continuity of care upon admission to the facility. The facility census was 77. On [DATE] at 3:43 P.M., the Licensed Nursing Home Administrator (LNHA), Director of Nursing (DON), and Director of Clinical Services #300 were notified Immediate Jeopardy began on [DATE] when Certified Nurse Practitioner (CNP) #205 ordered four milligrams (mg) of warfarin (generic for Coumadin) for Resident #80. Resident #80 was admitted to the facility on [DATE] with a primary diagnosis of acute bilateral subdural hemorrhage. Hospital discharge recommendations from neurology stated to hold off on anticoagulation therapy until the resident follows up with the neurosurgeon and schedule a neurology appointment as soon as possible (ASAP). The hospital discharge orders stated to discontinue the use of Coumadin. On [DATE], CNP #205 ordered to start Coumadin for atrial fibrillation. CNP #205 did not discuss this order to restart the medication Coumadin for Resident #80 with the physician or a neurosurgeon or cardiologist. Resident #80 continued with the use of Coumadin until he was discharged to the hospital. On [DATE], Resident #80 had voiced complaints of a headache that would not go away with medication and had weakness in his hands, and Resident #80 was sent to the hospital. On [DATE], while in the hospital, Resident #80 had an increase in subdural hemorrhage and required a craniotomy for subdural evacuation. Interviews with Physician #200 and CNP #205 stated they would not have started Resident #80 on Coumadin if it said in the hospital discharge orders not to. The Immediate Jeopardy was removed on [DATE] when the facility implemented the following corrective actions: (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: 366472	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/19/2024
NAME OF PROVIDER OR SUPPLIER Capri Gardens		STREET ADDRESS, CITY, STATE, ZIP CODE 6975 Graphics Way Lewis Center, OH 43035	

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE], the DON and designee reviewed all residents receiving Coumadin with Physician #200. One resident (#37) was identified to be currently on Coumadin and no new orders received. The DON or designee performed a head-to-toe assessment on Resident #37 and no adverse findings were noted. The appropriate dose was ordered, there was indication for use, and the facility implemented the physician's orders accurately. On [DATE], the DON and designee completed an initial audit to ensure the hospital after visit summaries were available, accurate, and implemented for all residents residing in the facility. No negative findings were noted. On [DATE], the DON re-educated all 24 licensed nurses on Coumadin best practices, new admission procedures, thoroughly reviewing the hospital after-visit summary to ensure continuity of care, order clarification and indications for use. On [DATE], the facility's Quality Assurance (QA) Committee, including Medical Director #200, held an impromptu QA Committee meeting to review the facility's Immediate Jeopardy, investigation, corrective actions, and audits. On [DATE], CNP #205 was re-educated by Medical Director #200 on ensuring residents receive the continuity of care upon admission to the facility, including following physician orders and recommendations following a hospital stay. Beginning [DATE], daily for four weeks, the DON will audit all new hospital after visit summaries to ensure accurate review and implementation; and all new orders, including new admission and Coumadin orders, to ensure accurate order transcription, indication for use, and implementation per the physician's order. The DON will be responsible for ongoing compliance. Although the Immediate Jeopardy was removed on [DATE], the facility remained out of compliance at Severity Level 2 (no actual harm with potential for more than minimal harm that is not Immediate Jeopardy) as the facility is in the process of implementing their corrective actions and monitoring to ensure on-going compliance. Findings include: Review of the closed medical record for Resident #80 revealed the resident was admitted to the facility on [DATE]. Diagnoses included nontraumatic acute subdural hemorrhage, chronic obstructive pulmonary disease, longstanding persistent atrial fibrillation, heart failure, and a personal history of transient ischemic attack. Review of the admission Minimum Data Set (MDS) assessment, dated [DATE], revealed Resident #80 had intact cognition evidenced by a Brief Interview for Mental Status (BIMS) assessment score of 14 (out of 15). (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the hospital after visit summary dated [DATE] revealed Resident #80 was admitted to the hospital with small acute bilateral subdural hemorrhage (SDH) on [DATE]. Resident #80 was admitted to the neuro intensive care unit (ICU). The hospital course was complicated by seizures and acute stroke. Hospital discharge recommendations included for the treatment of nontraumatic SDH, recommended to hold off on anticoagulation therapy until the resident followed up with neurosurgery and to schedule a neurology appointment ASAP. The after-visit summary also stated to stop taking warfarin two milligrams (mg). There were no anticoagulants listed under the Expected Medication List at Discharge. Review of Resident #80's admission physician orders dated [DATE] revealed there were no physician orders for anticoagulation medications. The admission assessment and baseline care plan confirmed admission orders have been verified with the physician. Review of CNP #205's progress note dated [DATE] revealed Resident #80 was seen for a follow-up on allergies, hypertension and SDH. Resident #80 was in the hospital from [DATE] to [DATE] for a headache and was found to have a small acute bilateral SDH. The hospital course and complications were noted. Under Assessment and Plan, it stated to continue beta blockers and anticoagulants for the treatment of atrial fibrillation; however, there were no anticoagulants ordered to continue at this time. The history of present illness stated the electronic medical record and hospital records were reviewed. There was no mention of the recommendation to hold off on anticoagulants until seen by neurosurgery as directed in the hospitals after visit summary dated [DATE]. The note addressed that Resident #80's medications were reviewed and reconciled, and it listed medications, which did not include any anticoagulants. There was no mention to start anticoagulants and any discussion with the physician or neurosurgeon to start anticoagulants. Review of the physician orders dated [DATE], revealed CNP #205 ordered Coumadin four mg for Resident #80. Review of Resident #80's Treatment Administration Record (TAR) dated [DATE] revealed the neurology appointment was scheduled for [DATE] at 12:30 P.M. Review of the physician's History and Physical dated [DATE] revealed Resident #80 was in the hospital from [DATE] to [DATE] for a headache. Resident #80 was found to have a small acute bilateral SDH. Under the Assessment and Plan, for the diagnosis of SDH, Resident #80 was sent to the hospital by the Coumadin Clinic on [DATE] due to headache. The Computed Tomography (CT) scan of his head and neck revealed acute bilateral SDH. Warfarin (Coumadin) managed per Coumadin clinic. For the diagnosis of atrial fibrillation, it stated to continue with beta blockers and anticoagulation therapy. Under medications reviewed and reconciliation completed, medications were listed, and they did not include anticoagulation medications. There was no mention of the hospital's after-visit summary recommendation to hold off on anticoagulation medications and if it was discussed with a neurologist or cardiologist. The History and Physical was electronically signed by Physician #200. There were no other physician progress notes or assessments in Resident #80's medical record. Review of CNP #205's progress notes dated [DATE], [DATE], and [DATE] revealed the CNP followed up on Resident #80. There was mention anticoagulation therapy was discussed with the physician and neurosurgeon during these visits. The notes did not address the recommendation to hold off on anticoagulants until seen by neurosurgery as noted in the hospital after visit summary dated [DATE]. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of Resident #80's progress notes revealed on [DATE] at 11:36 A.M., a family member of Resident #80 said she had to feed Resident #80 because he was having trouble controlling his fingers well enough to hold or handle utensils. On [DATE] at 11:45 A.M., Resident #80 had a headache that medication was not helping. A neuro assessment was completed with no other abnormalities other than weakness in his hands. Physician #200 was made aware, and he said to send Resident #80 to the emergency room for evaluation. Review of Resident #80's Medication Administration Record (MAR) dated [DATE] revealed Resident #80 did not receive Coumadin on [DATE], [DATE], and [DATE]. From [DATE] to [DATE] (except [DATE]), Resident #80 received Coumadin daily per physician orders. Review of the hospital records dated [DATE] revealed Resident #80 was admitted to the Neuro ICU from the emergency department. The history and physical documentation of the plan was to hold anticoagulation in the setting of new subdural hematomas. The CT scan showed an increase in size of bilateral SDH since [DATE]. The left side did not warrant intervention. The physician discussed with the family the recommendation would be a reversal of his anticoagulation, and the resident will be at high risk to resume anticoagulation given his SDH and right craniotomy. The family consented to surgery and on [DATE], Resident #80 had a right craniotomy with evacuation. On [DATE], the family was concerned about Resident #80 returning to the facility after hospitalization because of the medication error. On [DATE], Resident #80 was transferred to a neuro rehabilitation facility. Telephone interview on [DATE] at 11:01 A.M. with Physician #200 stated he doesn't remember reviewing Resident #80's discharge orders. Physician #200 stated it would make sense to hold the anticoagulants due to the diagnosis of SDH. Physician #200 stated he wouldn't have recommended starting Resident #80 on Coumadin if he saw it in the hospital discharge orders and after-visit summary. Physician #200 stated the documentation where he or the on-call physician would review medications would be in the nursing notes. Physician #200 stated he does not recall CNP #205 calling him the next day ([DATE]) to discuss starting Resident #80 on Coumadin. Telephone interview on [DATE] at 11:10 A.M. with CNP #205 stated the discharge orders she saw for Resident #80 were from the cardiologist that said to just be careful restarting Coumadin considering the atrial fibrillation. CNP #205 stated Physician #200 talked to the family about the risk and benefits of Coumadin; however, there was no documentation of this discussion in Resident #80's medical record. CNP #205 said the discharge orders she saw were from the cardiologist and not about the Coumadin. CNP #205 also stated if she saw the hospital discharge orders to hold anticoagulants until seen by the neurosurgeon dated [DATE], she would not have ordered the Coumadin for Resident #80 unless cardiology said to do it. CNP #205 verified she did not consult with Physician #200 or cardiology. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A subsequent telephone interview on [DATE] at 1:10 P.M. was held with CNP #205 along with the DON present. CNP #205 stated she was at the facility on [DATE] and Licensed Practical Nurse (LPN) #154 had the medication administration record and said Resident #80 was on Heparin (anticoagulant) at the hospital and Coumadin prior to the hospital. CNP #205 said Resident #80's wife was at bedside and she went in to talk to Resident #80's family. CNP #205 said she got the doses Resident #80 was on at the Coumadin clinic from the family. CNP #205 said she was going to be careful and restart it as it made sense to CNP #205 from the critical care standpoint. CNP #205 said Resident #80 could throw a clot due to therapy. CNP #205 said the hospital after-visit summary dated [DATE] was not available at that time or it wasn't uploaded into Resident #80's medical record. CNP #205 said she went by a cardiology note. CNP #205 reiterated that she went by a cardiology note as she did not have access to the after-visit summary at that time. CNP #205 stated if she had access to the after-visit summary at that time, she would not have started Resident #80 on the Coumadin. CNP #205 stated she went by the information she had at that time which was the cardiology notes and talking to the family. CNP #205 stated she goes by discharge orders. The DON said the after-visit summary was always there for them to review. CNP #205 said Physician #200 and she did not see it at that time. The DON said CNP #205, or Physician #200 typically asked for the after-visit summary and CNP #205 asked LPN #154 for it that day. The DON said she was not aware that CNP #205 did not have it. Interview on [DATE] at 1:43 P.M. with LPN #154 stated the floor nurse reviews the new admission's after-visit summary. LPN #154 stated she asks for clarification if she sees a new order that contradicts the after-visit summary. LPN #154 stated she told CNP #205 on [DATE] that she saw Resident #80 had a history of atrial fibrillation and he wasn't on atrial fibrillation medication at the time. LPN #154 said she told CNP #205 why Resident #80 was admitted to the hospital and asked her if the facility needed to continue Coumadin therapy. LPN #154 said it was her understanding that CNP #205 had access to the after-visit summary documentation. Interview on [DATE] at 12:06 P.M. with the DON stated the floor nurse, unit managers, or DON read and review an after-visit summary when a resident was admitted . The DON also stated when new orders come in, they get verified and signed off by CNP #205 or Physician #200 before going in the computer system. When CNP #205 or Physician #200's order contradicts discharge orders from a newly admitted resident, the nurse was to question the discrepancy and then document if the order still stands or needs to be changed. The DON doesn't believe she saw the documentation of Resident #80 when his order was questioned. Interview on [DATE] at 4:30 P.M. with Manager of Clinical Services #350 confirmed there was no cardiology note for Resident #80 from the hospital records dated [DATE] to [DATE] (in reference to CNP #205 stating she went by the cardiology note to start Resident #80 on Coumadin on [DATE]), and they don't have it. Manager of Clinical Services #350 stated the facility does not have a continuity of care policy. Review of a letter dated [DATE] from the [NAME] President of Post-Acute Operations #600 revealed CNP #205 had access to hospital records via MedOne's electronic medical record and the facility's electronic medical record on [DATE] for Resident #80. Review of a letter dated [DATE] from Physician #200 revealed he did have access to the medical records provided by the hospitals who refer residents. The access was via uploaded documents to the facility's electronic medical record software maintained by the facility. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the facility's policy titled Coumadin Best Practice dated [DATE] revealed upon admission, the nurse accepting the resident will call the attending physician/CNP and verify the orders for the residents Coumadin dose. This deficiency represents non-compliance investigated under Complaint Number OH00159587.