| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 375178 | A. Building<br>B. Wing | 03/15/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Stillwater Creek Skilled Nursing and Therapy | 1215 West 10th Street<br>Stillwater, OK 74074 |

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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0580<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.<br><br>41872<br><br>Based on record review and interview the facility failed to notify the physician when fingerstick blood sugar results were greater than 501 for one (#57) of one sampled resident reviewed for change in condition.<br><br>The Administrator identified 66 residents resided in the facility.<br><br>Findings:<br><br>A Resident's Family or Physician Notification of Change Guideline policy dated 12/01/09, read in part .The facility will .consult with the resident's physician .of the following events .A need to alter treatment significantly. (i.e. a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment) .<br><br>Resident #57 had diagnoses which included, heart failure and type two diabetes mellitus.<br><br>A physician order, dated 01/10/24, documented to administer Humalog Insulin subcutaneously before meals and at bedtime per sliding scale.<br><br>Resident #57's January and February 2024 MAR documented the resident was to be administered the following insulin on a sliding scale:<br><br>.Humalog Injection inject per sliding scale:<br><br>If 0-60 = 0 units, Give glucose recheck in 15 mins if still below 60 call MD;<br><br>61-149 = 0 units;<br><br>150-200 = 2 units;<br><br>201-250 = 4 units;<br><br>251-300 = 6 units;<br><br>301-350 = 8 units;<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: 375178 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 03/15/2024 |
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| F 0580<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 351-400 = 10 units;<br><br>401-450 = 12 units;<br><br>451-500 = 14 units;<br><br>501-999 = 16 units Call MD, subcutaneously before meals and at bedtime .<br><br>The clinical health record did not contain documentation the physician had been notified of the fingerstick blood sugar results on the following days;<br><br>a. On 01/27/24 FSBS was 528,<br><br>b. On 01/28/24 FSBS was 501 at 11 am, and 545 at 9 pm,<br><br>c. On 02/1/24 at 4 p.m. FSBS was 556,<br><br>d. On 02/5/24 at 4:00 p.m., FSBS was 501, and<br><br>e. On 02/10/24 at 11:00 a.m., FSBS was 544.<br><br>On 03/14/24 01:46 p.m., LPN #2 was asked where would the documentation be if the physician had been notified regarding an elevated fingerstick blood sugar. They stated it should generate a progress note.<br><br>On 03/14/24 02:27 p.m. the Corp Nurse Consult #1 was shown the January MAR and asked if there was any documentation the physician had been notified regarding the results greater than 501 on the following days: 01/27/24 FSBS was 528, and on 01/28/24 FSBS was 501 at 11 am, and 545 at 9 pm. The corporate nurse stated there was no documentation the physician had been notified.<br><br>On 03/14/24 02:28 p.m., the Corp. Nurse Consult #1 was shown the February 2024 MAR and asked if there was any documentation the physician had been notified regarding the results greater than 501 on the following days: On 2/1/24 at 4 p.m. FSBS was 556, on 2/5/24 at 4:00 p.m., FSBS was 501, and on 2/10/24 at 11:00 a.m., FSBS was 544. They stated they did not see any nursing documentation the physician had been notified. |

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| Stillwater Creek Skilled Nursing and Therapy | 1215 West 10th Street Stillwater, OK 74074 |

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| F 0637<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Assess the resident when there is a significant change in condition<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46387<br><br>Based on record review and interview, the facility failed to complete a significant change assessment for a resident with declines in ADLs for one (#48) of two sampled residents reviewed for ADLs.<br><br>The administrator identified 66 residents resided in the facility.<br><br>Findings:<br><br>An annual MDS, dated [DATE], documented Res #48 had no functional impairments in range of motion. The MDS documented Res #48 required setup/cleanup assistance with upper body dressing. The MDS documented Res #48 required supervision with walking 10 feet. The MDS documented Res #48 required partial/moderate assistance with lower body dressing and applying and removing footwear.<br><br>A quarterly MDS, dated [DATE], documented Res #48 had declined in range of motion and had impairments of upper and lower extremities on both sides. The MDS documented Res #48 had declined in their ability to perform toileting hygiene, and showering/bathing self and required partial/moderate assistance. The MDS documented Res #48 was newly dependent with upper and lower body dressing, and applying/removing footwear. The MDS documented Res #48 was newly dependent with walking 10 feet.<br><br>On 03/13/24 at 2:03 p.m., corporate MDS coordinator #1 stated the significant change had been missed and should have been completed. |

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| NAME OF PROVIDER OR SUPPLIER Stillwater Creek Skilled Nursing and Therapy | | STREET ADDRESS, CITY, STATE, ZIP CODE 1215 West 10th Street Stillwater, OK 74074 | |

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| F 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.<br><br>41872<br><br>Based on record review and interview the facility failed to update a care plan with smoking interventions for one #57) of one sampled resident reviewed for smoking.<br><br>The Administrator identified 66 residents resided in the facility and the list of smoking residents documented eleven residents smoked.<br><br>Findings:<br><br>A Smoking Policy and Procedure revised 02/24/20, read in part .To offer the resident the ability to smoke free of danger to self and others .The resident may choose to utilize an electronic cigarette .physicians should be notified to appropriately update care plan and set goals for residents regarding smoking habits .<br><br>Resident #57 had diagnoses which included, heart failure and type two diabetes mellitus.<br><br>Resident #57's care plan did not have any interventions or safety measures implemented for smoking.<br><br>On 03/11/24 at 12:59 p.m., Resident #57 was asked if they smoked. They stated that they were and was able to smoke when they wanted.<br><br>On 03/12/24 12:44 p.m., the Administrator was asked if Resident #57 was a smoker. They stated the resident had signed a smoking contract, had started smoking cigarettes and had used electronic cigarettes vaped when they admitted .<br><br>On 03/14/24 11:55 a.m., the corporate nurse was shown the care plan and asked if there were any interventions for smoking. They stated No. They were asked if the care plan should identify the resident as a smoker. They stated if the resident is a smoker it should be care planned.<br><br>On 03/12/24 12:45 p.m. the corporate nurse was shown the smoking assessment ,dated 02/02/24, and stated the assessment documented the resident was a smoker and it should have been care planned. |

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| NAME OF PROVIDER OR SUPPLIER Stillwater Creek Skilled Nursing and Therapy | | STREET ADDRESS, CITY, STATE, ZIP CODE 1215 West 10th Street Stillwater, OK 74074 | |

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| F 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide appropriate pressure ulcer care and prevent new ulcers from developing.<br><br>46387<br><br>Based on observation, record review, and interview, the facility failed to prevent development of new pressure ulcers for one (#15) of one sampled residents reviewed for pressure ulcers.<br><br>Corporate consult RN #1 identified six residents resided in the facility with pressure ulcers.<br><br>Findings:<br><br>Res #15 had diagnoses which included quadriplegia, pressure induced deep tissue damage of left heel, and pressure ulcer of sacral region stage IV.<br><br>A physician order, dated 02/12/24, documented heel lift boots in place every shift for wound prevention.<br><br>A care plan, reviewed 02/13/24, documented Res #15 was to have heel lift boots in place every shift, and staff were to float heels with pillows while in bed.<br><br>A weekly skin evaluation, dated 03/11/24 at 11:08 a.m., documented Res #15 had no new skin issues.<br><br>On 03/12/24 at 9:15 a.m., Res #15 was observed in bed on their back. Both feet were observed without any pressure relieving devices in place. The resident's bare feet were observed pressed into the footboard of the bed. The right great toe, second toe, and third toe were observed curling under from pressure/contact with the footboards. No offload or pressure reducing devices were observed in the resident's room.<br><br>On 03/12/24 at 12:15 p.m., Res #15 was observed during medication administration. The resident's bare feet continued to be pressed against the footboard without any offload/pressure reduction devices in place.<br><br>A nurse progress note, dated 03/12/24 at 5:10 p.m., documented a post-wound assessment of the sacral wound. The note documented the left heel deep tissue injury was stable. The note did not document any new discoloration or pressure injuries.<br><br>On 03/13/24 at 9:53 a.m., wound nurse #1 was observed providing ordered wound care for Res #15. The resident was observed to have a new purple area to right great toe. The nurse was made aware and stated they would have to contact the provider.<br><br>A nurse progress note, dated 03/13/24 at 10:22 a.m., documented a new purple discoloration was noted to left great toe. The note documented the resident also had a new purple area to the right heel.<br><br>On 03/13/24 at 11:33 a.m., CNA #3 stated the resident was supposed to wear offload boots daily. They stated if they were not in place they were to notify the nurse. They stated they could not recall if they were in place yesterday.<br><br>(continued on next page) |

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| NAME OF PROVIDER OR SUPPLIER Stillwater Creek Skilled Nursing and Therapy | | STREET ADDRESS, CITY, STATE, ZIP CODE 1215 West 10th Street Stillwater, OK 74074 | |

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| F 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | On 03/13/24 at 11:37 a.m., LPN #1 stated the nurses and aides were responsible for ensuring the pressure reduction devices were in place. They stated they had noticed yesterday the boots were not in place and had not located them in the room. They stated they meant to go get them and place them on the resident but did not. They stated they did not notify anyone the offload boots were not in place. |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide safe and appropriate respiratory care for a resident when needed.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46387<br><br>Based on observation, record review, and interview, the facility failed to obtain orders for continuous oxygen and failed to ensure oxygen tubing was changed and dated per physician orders for two (#1 and #9) of two sampled residents reviewed for oxygen administration.<br><br>Corporate consult RN #1 identified 13 residents received oxygen in the facility.<br><br>Findings:<br><br>1. Res #1 had diagnoses which included COPD.<br><br>A physician order, dated 11/17/22, documented to administer oxygen at 2 liters per minute as needed to maintain oxygen saturation above 89%.<br><br>A physician order, dated 11/17/22, documented to change oxygen tubing and humidifier bottle monthly on the 15th on night shift. The order documented to date tubing.<br><br>A quarterly MDS, dated [DATE], documented Res #1 was cognitively intact.<br><br>On 03/11/24 at 12:22 p.m., Res #1 was observed in bed with oxygen being administered via nasal cannula from a concentrator. The tubing was observed without a date indicating when it was last changed. The humidification bottle on the concentrator was observed without a date indicating when it was last changed. The oxygen was observed to be set at 2 liters per minute. The resident stated they required oxygen most of the time to ensure their levels remained up. They stated they felt they needed the oxygen continuously. They stated they were unsure the last time the tubing and humidification bottle was changed.<br><br>On 03/12/24 at 11:41 a.m., Res #1 was observed in bed with oxygen being administered via nasal cannula. The oxygen concentrator was set at 4 liters per minutes.<br><br>On 03/12/24 at 3:16 p.m., LPN #1 was asked to accompany the surveyor to Res #1's room. The LPN stated the oxygen concentrator was set at 4 liters per minutes. The LPN reviewed the resident's orders and stated there was not an order for continuous oxygen. They stated the as needed order was for 2 liters per minute.<br><br>2. Res #9 had diagnoses which included COPD.<br><br>A physician order, dated 09/06/23, documented to administer oxygen via nasal cannula at 2 liters per minute as needed.<br><br>A physician order, dated 11/15/23, documented to change oxygen tubing and humidifier bottle monthly on the 15th on night shift. The order dated to date the tubing.<br><br>A significant change MDS, dated [DATE], documented Res #1 was cognitively intact.<br><br>(continued on next page) |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | On 03/11/24 at 12:56 p.m., Res #1 was observed seated in bed. The resident was observed with oxygen being delivered via nasal cannula from a concentrator. The concentrator was observed set at 3 liters per minute. A portable oxygen tank on the resident's wheelchair was observed set at 3.5 liters per minute. The tubing attached to the concentrator was not dated. The humidifier bottle on the concentrator was not dated. The tubing attached to the portable bottle on the wheelchair was not dated. The resident stated they required oxygen all the time. They stated their oxygen tubing had never been changed. They removed the tubing from their nose and pointed out the cannula was discolored. The cannula was observed with a slight yellow tinge to the tubing.<br><br>A physician order, dated 03/13/24, documented to administer oxygen at 3 liters per minute continuously.<br><br>On 03/13/24 at 1:18 p.m., Res #9 was observed transferring self from wheelchair to bed. The resident's portable oxygen was observed set at 2 liters per minute. The bedside concentrator was observed set at 2 liters per minute.<br><br>On 03/14/24 at 10:35 a.m., LPN #1 stated the order for continuous oxygen was obtained after they had noted the resident only had orders for as needed oxygen. The LPN stated the resident had recently been requiring the oxygen all the time. The LPN stated the oxygen was ordered at 3 liters per minute. |

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| F 0698<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide safe, appropriate dialysis care/services for a resident who requires such services.<br><br>33148<br><br>Based on record review and interview, the facility failed to ensure there was ongoing assessment of a resident on dialysis for one (#54) of one sampled resident reviewed for dialysis services.<br><br>The administrator identified two residents received dialysis services.<br><br>Findings:<br><br>A Guidelines for Dialysis After Care policy and procedure, dated 07/11/12, read in part, .Inspection of the AVF .access and entire access extremity including hands or feet .Presence/absence or thrill and/or bruits . Signs and Symptoms of infection .Bruising and/or bleeding .Peripheral Pulses .Erosion of Skin or Sores over access site .Post dialysis dressing removal includes .Dressing should be removed 4 hours after dialysis treatment .<br><br>Res #54 had diagnoses which included ESRD.<br><br>Physician orders, dated 02/02/24, documented, dialysis Tuesday, Thursday, and Friday; check AVF for thrill and bruit every shift. If absent notify the physician; monitor AVF for s/s of trauma and/or infection every shift; and remove AVF dressing four hours after dialysis treatment.<br><br>The February and March 2024 dialysis communication forms and skilled nurses' notes were reviewed. There was no documentation 20 out of 58 opportunities the AVF was checked for thrill and bruit, monitored for s/s of trauma, and/or infection every shift. There was no documentation seven out of 13 opportunities the AVF dressing was removed four hours after dialysis treatment.<br><br>On 03/12/24 at 12:46 p.m., the ADON was asked where it was documented when a resident on dialysis had physician orders for ongoing assessment. They stated it would be documented on the TAR. They stated they would check the TARs for Res #54.<br><br>On 03/12/24 at 12:58 p.m., the ADON stated they used the dialysis communication form consistently to document everything. They were made aware the form did not document the resident being checked for thrill and bruit each shift, monitored for s/s of trauma and/or infection each shift, or the dressing changed after dialysis.<br><br>On 03/12/24 at 1:04 p.m., the ADON stated the daily skilled nurses' notes documented they monitored for dialysis management. They were asked what it indicated when the dialysis management box was checked. They stated it meant they assessed the resident.<br><br>On 03/12/24 at 1:17 p.m., corporate nurse consultant #1 stated they had daily skilled nurses notes documenting dialysis management. They stated they followed policy for monitoring, but not for following physician orders to monitor each shift. |

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| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46387<br><br>Based on observation, record review and interview, the facility failed to ensure medications were administered according to physician orders for one (#12) of five sampled residents reviewed for unnecessary mediations.<br><br>The administrator identified 66 residents resided in the facility.<br><br>Findings:<br><br>Res #12 had diagnoses which included diabetes, coronary artery disease, and hypertension.<br><br>A physician order, dated 09/14/23, documented to administer insulin glargine subcutaneous solution 20 units subcutaneously two times a day for diabetes at 6:00 a.m. and 9:00 p.m.<br><br>A physician order, dated 09/14/23, documented to administer insulin aspart subcutaneous solution per sliding scale: if 0 - 150 = 0; 151 - 200 = 2; 201 - 250 = 4; 251 - 300 = 6; 301 - 350 = 8; 351 - 400 = 10; 401 - 450 = 12; 451 - 999 = 12 For FSBS greater than 450, give 12 units and notify MD for further instructions before meals and at bedtime related to diabetes.<br><br>A physician order, dated 11/23/23, documented to administer Victoza subcutaneous solution 1.2 mg one time per day at 6:00 a.m. for diabetes.<br><br>A physician order, dated 12/09/23, documented to administer amlodipine besylate oral tablet 10 mg one time per day for hypertension. The order documented to hold the medication if the systolic blood pressure was below 110, the diastolic blood pressure was below 60, or the pulse was below 60.<br><br>A physician order, dated 12/09/23, documented to administer losartan potassium oral tablet 50 mg one time per day for hypertension. The order documented to hold the medication if the systolic blood pressure was below 110, or the diastolic blood pressure was below 60.<br><br>A physician order, dated 12/09/23, documented to administer carvedilol oral tablet 6.25 mg two times per day for hypertension. The order documented to hold the medication if systolic blood pressure was below 110, diastolic blood pressure below 60, or pulse below 60.<br><br>A quarterly MDS, dated [DATE], doucmented the resident was cognitively intact.<br><br>A MAR for January 2024 documented Res #12's blood pressure was 128/57 on 01/04/24, 125/57 on 01/08/24, 163/50 on 01/10/24, and 139/49 on 01/20/24. The MAR documented Res #12 received their amlodipine on 01/08/24, 01/10/24, and 01/20/24. The MAR documented Res #12 received their losartan on 01/20/24. The MAR documented Res #12 received the carvedilol on 01/04/24, 01/10/24, and 01/20/24.<br><br>(continued on next page) |

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| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | An insulin administration record for January 2024, documented Res #12's Victoza was administered greater than one hour after the prescribed administration time on 01/24/24 and 01/28/24. The administration record documented the insulin glargine was administered greater than one hour after the prescribed time for the 6:00 a.m. dose on 01/10/24, and 01/28/24. The administration record documented the 4:00 p.m. dose of insulin aspart was administered greater than one hour after prescribed time on 01/04/24. The record documented the 6:00 a.m. dose was administered greater than one hour after the prescribed time on 01/05/24. The insulin aspart 01/05/24 4:00 p.m. dose was blank.<br><br>A MAR for February 2024 documented Res #12's blood pressure was 139/49 on 02/10/24. The MAR documented Res #12 received the carvedilol on 02/10/24.<br><br>An insulin administration record for February 2024, documented Res #12 Victoza was administered greater than one hour after the prescribed administration time on 02/01/24, 02/07/24, and 02/17/24. The administration record documented the insulin glargine was administered greater than one hour after the prescribed time for the 6:00 a.m. dose on 02/07/24, and 02/17/24, and the 9:00 p.m. dose was administered greater than one hour after the prescribed administration time on 02/13/24.<br><br>An insulin administration record for March 2024, documented Res #12's Victoza was administered greater than one hour after the prescribed administration time on 03/03/24, 03/09/24, and 03/10/24. The administration record documented the insulin glargine was administered greater than one hour after the 6:00 a.m. prescribed time on 03/03/24 and 03/09/23. The administration record documented the 9:00 p.m. dose of insulin glargine on 03/10/24 was not administered.<br><br>On 03/11/24 at 11:45 a.m., Res #12 was observed in their room in the bed. The resident stated they often received their medications late.<br><br>On 03/14/24 at 9:59 a.m. CMA #2 stated the blood pressure medications should have been held on the above dates because the blood pressure was out of parameters.<br><br>On 03/14/24 at 10:09 a.m. LPN #1 stated insulin can be administered an hour before to an hour after the prescribed time. They were shown the above dates and stated the insulin was administered late. They stated the blanks on the MAR meant the medication was not given. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 375178 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 03/15/2024 |
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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Stillwater Creek Skilled Nursing and Therapy | 1215 West 10th Street Stillwater, OK 74074 |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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|---|---|
| F 0756<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures.<br><br>46387<br><br>Based on record review and interview, the facility failed to ensure a medication regimen review was responded to timely for one (#9) of five sampled residents reviewed for unnecessary medications.<br><br>The administrator identified 66 residents resided in the facility.<br><br>Findings:<br><br>Res #9 had diagnoses which included bipolar disorder, insomnia, and depression.<br><br>A physician order, dated 09/07/23, documented to administer Zoloft oral tablet 50 mg one time per day for depression.<br><br>A physician order, dated 09/07/23, documented to administer Abilify oral tablet 2 mg one time per day for bipolar disorder.<br><br>A physician order, dated 10/18/23, documented to administer Trazodone HCL oral tablet 300 mg at bedtime for bipolar disorder.<br><br>A monthly medication review, dated 12/18/23, documented the pharmacist request to attempt a gradual dose reduction of the residents Zoloft, Abilify, or trazodone. The medication review was not documented as responded to until 02/12/24 in which the physician declined the GDR.<br><br>On 03/14/24 at 2:51 PM, Corporate consult RN #1 stated if there is not a response within 30 days to a monthly medication review the facility must go to the medical director. |

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| F 0757<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure each resident’s drug regimen must be free from unnecessary drugs.<br><br>41872<br><br>Based on record review and interview the facility failed to monitor for side effects related to the use of Warfarin for one (#62) of one sampled resident reviewed anticoagulant use.<br><br>The Administrator identified 66 residents resided in the facility.<br><br>Findings:<br><br>Resident #62 had diagnoses which included hemiplegia and hemiparesis following cerebral infarction.<br><br>September, October, November, December and January MAR's documented Resident #62 had been administered Warfarin as ordered by the physician.<br><br>The clinical health record did not document Resident #62 had been monitored for side effects related to the use of Warfarin from 09/08/23 through 01/22/24.<br><br>Resident #62's TAR, dated 01/22/24, read in part .Monitor: Nose/gum bleeding, coughing or bloodtinged sputum, hematuria, black/tarry stools, vomiting of blood or coffee ground-like material, abnormal or excessive bruising, low b/p, Change in cognition, cyanosis, every shift for anti-coagulation therapy Warfarin .<br><br>On 03/12/24 at 02:21 p.m. the Corp. Nurse Consultant #1 was asked if Resident #62 had been monitored for side effects in the months of September, October, November, and December 2023. They stated there were no orders to monitor for side effects until January 2024. |

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| F 0758<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.<br><br>33148<br><br>Based on record review and interview, the facility failed to ensure:<br><br>a. behavior and side effect monitoring was conducted for the use of psychotropic medications for one (#127), and<br><br>b. PRN antianxiety medications were limited to 14 days for one (#9) of five sampled residents reviewed for unnecessary medications.<br><br>Corporate Nurse Consultant #1 identified 11 residents had orders for routine psychotropic medications and six residents had orders for PRN antianxiety medications.<br><br>Findings:<br><br>A Medications Requiring Behavior and Effect Monitoring policy, dated 10/25/21, read in part, .Antipsychotics . required monitoring .Targeted Behaviors, Side Effects .quetiapine .<br><br>1. Res #127 had diagnoses which included dementia with other behavioral disturbance.<br><br>A physician's order, dated 03/04/24, documented quetiapine fumarate (antipsychotic medication) 100 mg. Give one tablet by mouth at bedtime. End date 03/06/24.<br><br>A physician's order, dated 03/06/24, documented quetiapine fumarate 150 mg. Give 0.5 tablet by mouth bedtime for three days. End date 03/09/24.<br><br>A physician's order, dated 03/10/24, documented quetiapine fumarate 50 mg. Give one tablet by mouth bedtime for three days. End date 03/13/24.<br><br>There was no documentation behaviors and side effect were monitored 03/04/24 through 03/12/23.<br><br>On 03/14/24 at 11:24 a.m., the administrator was asked to provide behavior and side effect monitoring for 03/04/24 through 03/12/24 for the use of quetiapine fumarate.<br><br>On 03/14/24 at 12:25 p.m., the administrtaor stated there was no documentation behaviors and side effects were monitored. They stated they should have been monitored. They stated it was overlooked.<br><br>46387<br><br>2. Res #9 had diagnoses which included anxiety disorder.<br><br>A physician order, dated 04/13/23, documented to administer Ativan oral tablet 0.5 mg every 12 hours as needed for anxiety.<br><br>(continued on next page) |

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| F 0758<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | A monthly medication review, dated 05/01/23, documented the pharmacist's request to add a stop date to the as needed Ativan order per regulations. There was no documented stop date to the order until 08/05/23.<br><br>A MAR for May 2023 documented Res #9 received the as needed Ativan 33 times.<br><br>A MAR for June 2023 documented Res #9 received the as needed Ativan 25 times.<br><br>A MAR for July 2023 documented Res #9 received the as needed Ativan 29 times.<br><br>A MAR for August 2023 documented Res #9 received the as needed Ativan four times. The order was discontinued on 08/05/23.<br><br>On 03/14/24 at 3:00 p.m. Corporate consult RN #1 stated a 14 day stop date was not added to the order. |

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| F 0770<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide timely, quality laboratory services/tests to meet the needs of residents.<br><br>46387<br><br>Based on record review and interview the facility failed to obtain laboratory studies as ordered for one (#5) of five sampled residents reviewed for unnecessary medications.<br><br>The administrator identified 66 residents resided in the facility.<br><br>Findings:<br><br>Res #5 had diagnoses which included hypokalemia.<br><br>A lab result, dated 06/20/23, documented Res #5 had a low potassium level. A handwritten note on the result documented the nurse practitioner was notified, and a new order was received to administer potassium 10 meq and repeat CMP on 6/26/23.<br><br>A nurse progress note, dated 6/23/2023 at 12:33 p.m., documented a focused assessment related to labs. CBC, CMP and lipid panel sent to nurse practitioner for review. New orders to give KCL 20 meq now and repeat CMP on Monday 06/26/23.<br><br>On 03/12/24 at 4:08 p.m., the missing labs were requested from the ADON.<br><br>On 03/15/24 at 9:14 a.m., the administrator stated it was their understanding that the facility was unable to locate documentation for the repeat lab on 6/26/23. |