

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 375581	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/31/2024
NAME OF PROVIDER OR SUPPLIER Cearu Medical Resort		STREET ADDRESS, CITY, STATE, ZIP CODE 8720 South 101st Avenue Tulsa, OK 74133	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0684</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34270</p> <p>A past noncompliance Immediate Jeopardy (IJ) situation was determined to exist effective [DATE], related to the facility's failure to ensure a nurse practitioner (NP #1) did not give a verbal order to a facility admission nurse (LPN #1) to reduce all enoxaparin (an anticoagulant medication) orders coming from acute care hospitals to a three-day course. The facility failed to ensure Resident #1 received their full 30-day course of enoxaparin as ordered by an acute care hospital physician which had the potential to result in serious injury or harm.</p> <p>On [DATE], the Oklahoma State Department of Health verified the existence of the past noncompliance IJ related to the facility's failure to ensure physician medication orders were followed as written.</p> <p>The past noncompliance IJ was removed effective [DATE] after the facility put measures in place to prevent recurrence. On [DATE] NP #1 and LPN #1 were in-service about following hospital discharge orders from acute care hospitals until a facility provider assessed the resident and wrote new orders. On [DATE] the facility initiated monitoring of hospital discharge medication orders for current and new admissions. On [DATE] the facility's Quality Assurance and Performance Improvement Committee documented performance improvement measures regarding admission order oversight. On [DATE] staff were in-serviced on admission checklists and medication errors.</p> <p>An IJ was identified from [DATE] through [DATE].</p> <p>Based on record review and interview, the facility failed to ensure a NP did not give a verbal order to decrease all enoxaparin orders from acute care hospitals to three days and failed to ensure a resident received their full course of enoxaparin as ordered by a physician for one (#1) of four sampled residents reviewed for medications administered as ordered.</p> <p>The QA nurse identified two current residents at the facility had been prescribed the anticoagulant medication enoxaparin.</p> <p>Findings:</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0684</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>A facility policy titled Admission Orders, dated [DATE], read in part, The orders should allow facility staff to provide essential care to the resident consistent with the resident's mental and physical status on admission. The policy further read in part, The orders should provide information to maintain or improve the resident's functional abilities until staff can conduct a comprehensive assessment and develop an interdisciplinary comprehensive care plan.</p> <p>Resident #1 had diagnoses which included a fracture of an unspecified part of the neck of the left femur, atrial fibrillation, and thrombophilia (a blood disorder where a person's blood is more likely to clot).</p> <p>An acute care hospital discharge planning note, dated [DATE] at 9:00 a.m., documented Resident #1's discharge medication list included enoxaparin 30 mg/0.3 ml injections to be administered once daily starting on [DATE] with a total of nine milliliters to have been administered during the full course of the medication (9 ml divided into daily doses of 0.3 ml equates to 30 days of injections).</p> <p>A facility medication order, dated [DATE] at 12:52 p.m., read in part, Enoxaparin Sodium Injection Solution Prefilled Syringe 30 MG/0.3 ML (Enoxaparin Sodium) Inject 30 mg subcutaneously one time a day for anticoagulation for 3 days CONFIRM ORDER WITH MD/NP, ORDER ONLY X 3 DAYS.</p> <p>A medication administration record, dated [DATE], read in part, Enoxaparin Sodium Injection Solution Prefilled Syringe 30 MG/0.3 ML (Enoxaparin Sodium) Inject 30 mg subcutaneously one time a day for anticoagulation for 3 days CONFIRM ORDER WITH MD/NP, ORDER ONLY X 3 DAYS. Start date [DATE] at 0700. The record documented LPN #2 administered a dose of the medication on [DATE] and LPN #3 administered one dose of the medication on [DATE] and another on [DATE]. The record had no other documentation of the resident having received additional doses.</p> <p>A nurses note created by LPN #2, dated [DATE] at 12:07 p.m., documented Resident #1 had been found in bed with their eyes open, right sided facial drooping, significant right sided weakness, and the inability to speak. The note further documented this was abnormal for the resident whose baseline had been alert and oriented with the ability to speak clearly and walk with the use of a walker. The note had an effective date of [DATE] at 8:30 a.m.</p> <p>An acute care hospital Emergency Department Encounter document, dated [DATE] at 10:29 a.m., documented Resident #1 had been seen in the emergency department with the chief complaint of cerebrovascular accident symptoms. The document noted the resident had presented in the emergency department with aphasia [loss of the ability to express or understand speech], right sided facial drooping, and right sided weakness. The document further noted the final diagnosis was acute cerebrovascular accident.</p> <p>A hospital Death Summary Note, dated [DATE] at 8:36 a.m., documented Resident #1 died at the hospital on [DATE] at 8:36 a.m. The resident's diagnoses at death were acute left MCA ischemic stroke (a stroke that caused damage to the left side of the brain), paroxysmal atrial fibrillation, essential hypertension, and metabolic encephalopathy.</p> <p>On [DATE] at 8:35 a.m., the DON stated when a new resident was admitted the discharge orders from the hospital were accepted as the admission orders and put into the EHR under the name of their house physician. They stated at the time Resident #1 was admitted they had physician #1 and physician #2 as the attending physicians. They stated physician #1 was their medical director and physician #2 did rounds routinely.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>On [DATE] at 9:52 a.m., the DON stated physician #2 had seen Resident #1 on [DATE].</p> <p>On [DATE] at 10:12 a.m., LPN #3 stated they did recall caring for Resident #1. They stated the [DATE] TAR did indicate they had given two doses of enoxaparin injection to the resident. They stated they were unaware of the portion of the order that said to confirm the order with a physician or nurse practitioner regarding the order being for three days only. LPN #3 stated they would not have known about that part of the order because it would not have been visible on their computer screen. LPN #3 demonstrated by opening the EHR to the screen they use to note administration of medication and they pointed out the word More that was visible to the side of the medication order. They stated if the order narrative was very long the excess of the narrative would be hidden and a person would need to hover their cursor over the word More to see the rest of it. They stated Lovenox (enoxaparin's brand name) was not a medication that would cause them to look under the More link.</p> <p>On [DATE] at 11:41 a.m., NP #1 stated they had been off work from [DATE] through [DATE] around noon. They stated Resident #1 had left the facility before they had returned to work on [DATE].</p> <p>On [DATE] at 12:05 p.m., Physician #1 stated they had not seen Resident #1 and physician #2 would have visited with them. They stated admission orders were often put in under their name, but they had never seen the enoxaparin order for Resident #1. They stated they had not signed that order and they would not have authorized it. They stated Resident #1 should have received the enoxaparin for 30 days and that was standard practice. They stated if that order was changed someone should have documented the reason why. They stated they were unaware of the order to reduce all enoxaparin to three days.</p> <p>On [DATE] at 12:10 p.m., NP #1 stated they had been off work when Resident #1 had been admitted . They stated the had never seen Resident #1 while they were a resident at the facility. They stated when a new admission came to the facility, they look over the discharge orders and discontinue enoxaparin after three days, then restart Eliquis (an oral anticoagulant medication) if they had been on it before. They stated they were required to do what their supervising physician wanted, and it was their understanding that was what they wanted. They stated their supervising physician worked in corporate and was not the facility medical director (physician #1).</p> <p>On [DATE] at 12:33 p.m., LPN #1 stated it was one of their jobs to enter admission orders into the residents' electronic health record. They stated the orders used for the admission orders where the discharge orders from the hospital from where the residents had come from. They were asked to look at the enoxaparin order for Resident #1, dated [DATE], and to calculate the number days the resident was to have been administered that medication. They departed the room to make the calculation.</p> <p>On [DATE] at 1:10 p.m., LPN #1 returned and stated the resident should have received that medication for 30 days. They were asked what was on the order. They stated three days. They stated they had entered the order for three days and the note to confirm the order with a physician or nurse practitioner because it was for three days. They stated it was changed to three days because NP #1 had given them a verbal order in the past to change all enoxaparin orders coming from hospitals to three days. They stated they did not have any documentation of the verbal order to change those orders to three days. They stated they understood enoxaparin was an anticoagulant.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>On [DATE] at 1:20 p.m., NP #1 stated they and LPN #1 had discussed reducing the enoxaparin orders down to three days, but LPN #1 was hesitant without consulting with a physician. They stated they told LPN #1 to go ahead and put in the reduced days for the enoxaparin orders because a physician would see the residents before that time was up and they could continue or change the medication. They stated the administration was currently aware of that order but was unsure if they were in the past.</p> <p>On [DATE] at 1:36 p.m., the DON stated they had become aware of the three-day verbal order from NP #1 after the incident with Resident #1 that occurred on [DATE].</p> <p>On [DATE] at 1:54 p.m., LPN #1 stated they had been given the verbal order to reduce the enoxaparin days from NP #1 in [DATE]. They stated they have since stopped the practice after the DON told them to stop.</p> <p>On [DATE] at 2:30 p.m., Physician #2 stated they usually kept residents such as Resident #1 on enoxaparin for 30 days. They stated they did see the order for enoxaparin, but it did not register with them the order would not be for 30 days. They stated that medication should have been continued for a minimum of 14 days and up to 30 days. They stated they owned part of that mess as they had not seen the portion of the order to confirm the three days.</p> <p>On [DATE] at 5:37 p.m., the facility executive director stated NP #1 was not following policy and procedure when they gave the verbal order to reduce all enoxaparin orders to LPN #1. They stated the facility staff has taken positive steps to ensure such incident would not be repeated including hiring a full time QA nurse.</p>