STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	385144	A. Building B. Wing	07/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Clatsop Care Center	646 16th Street Astoria, OR 97103

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 0760 Level of Harm - Actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. 46054 Based on interview and record review it was determined the facility failed to properly administer anticoagulant medication to 1 of 2 sampled residents (#2) reviewed for medications. As a result, Resident 2 was hospitalized and required Vitamin K infusion (used as reverse the effects of blood thinning medications). Findings include: Resident 2 was admitted to the facility in 5/2021, with diagnosis including paroxysmal atrial fibrillation (irregular heart beat caused by poor blood flow). Resident 2's 5/20/22 Care Plan noted the resident received Coumadin (an anticoagulant medication) related to atrial fibrillation. Resident 2's 5/2022 physician orders indicated Resident 2 was to be administered Coumadin 5 mg daily every Tuesday, Friday, and Sunday at 4:00 PM. A review of Resident 2's 11/2023 MAR revealed the following dates and times the resident's Coumadin was administered: - 5 mg on 11/3/23 at 8:00 AM - 5 mg on 11/3/23 at 4:00 PM - 5 mg on 11/5/23 at 8:00 AM - 5 mg on 11/5/23 at 4:00 PM - 5 mg on 11/7/23 at 8:00 AM - 5 mg on 11/7/23 at 4:00 PM - 5 mg on 11/10/23 at 8:00 AM - 5 mg on 11/10/23 at 4:00 PM - 5 mg on 11/12/23 at 8:00 AM (continued on next page)

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Actual harm Residents Affected - Few	- 5 mg on 11/12/23 at 4:00 PM An 11/14/23 facility investigation revealed Staff 4 (LPN) inputted a duplicate order of Coumadin, which resulted in Resident 2 receiving two doses of Coumadin for six days. The investigation noted Resident 2 was sent to the emergency department after lab test revealed critical lab results. Resident 2's 11/15/23 Progress Note indicated the resident received a Vitamin K infusion while at the hospital. On 7/15/24 at 11:58 AM, Staff 4 (LPN) stated he ordered a duplicate medication of Coumadin, which resulted in Resident 2 receiving extra Coumadin for six days. On 7/11/24 at 12:56 PM, Staff 1 (Administrator) confirmed findings and indicated Resident 2 received a Vitamin K infusion while at the hospital as a result of the medication error. On 11/20/23, the Past Non-Compliance was corrected when the facility completed a root cause analysis of the incident and determined there was medication error. The Plan of Correction included: 1. The effected resident was assessed and sent the emergency department for Vitamin K infusion. 2. An audit of all anticoagulant orders were reviewed for accuracy. 3. All nursing staff were provided education related to administration of Coumadin including warning systems to prevent duplicate orders. 4. Education was received by consultant pharmacist on avoiding medication errors. 5. Anticoagulation orders for residents continued to be monitored and triple checked for accuracy.