STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	425070	A. Building B. Wing	04/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Myrtle Beach Manor	9547 Highway 17, North Myrtle Beach, SC 29572

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 - 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. 31846 Based on review of facility policy, record review, and interview, the facility failed to notify Resident (R)1's attending physician of elevated lab values resulting in a hospital stay for 1 of 1 residents reviewed for quality of care. Findings include: Review of the undated facility policy titled, Notification of Changes revealed under policy, The purpose of this policy is to ensure the facility promptly informs the resident, consults with the resident's physician, and notifies, consistent with his or her authority, the resident's representative when there is a change requiring notification. Circumstances requiring notification include. 2. Significant change in the resident's physical, mental or psychosocial condition such as deterioration in health, mental or psychosocial status. This may include a. Life-threatening conditions, or b. Clinical complications. 3. Circumstances that require a need to alter treatment. This may include: a. New treatment. b. Discontinuation of current treatment due to: I. Adverse consequences. II. Acute Condition. III. Exacerbation of a chronic condition . 4. A transfer or discharge of the resident from the facility. Review of the undated facility policy titled Lab and Diagnostic Test - Clinical Protocol revealed, 3. A nurse will identify the urgency of communicating with the Attending Physician based on physician request, the seriousness of any abnormality, and the individual's current condition. Identifying Situations that Warrant Immediate Notification . 2. High or toxic serum medication levels. If a test was obtained to monitor the blood level of a medication and the level is reported as high (above therapeutic range) or toxic, the nurse will notify the physician promptly and will not give the next dose until the situation has been reviewed with the physician. Options for Physician Notification .b. Direct voice communication with the physician is the preferred means for presenting any results requiring immediate notification, especially when the resident's clinical status is unstable or current treatment needs review or clarification. Review of R1's Face Sheet revealed the facility admitted R1 on 12/18/23 with diagnoses including, but not limited to: history of aortic valve replacement, atrial fibrillation, and atherosclerotic heart disease. Further review of R1's Face Sheet revealed, R1 was admitted with an INR (international normalized ratio, a type of calculation based on the prothrombin time) of 2.7. (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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NAME OF PROVIDER OR SUPPLIER Myrtle Beach Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 9547 Highway 17, North Myrtle Beach, SC 29572	

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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 - Actual harm Residents Affected - Few	Review of R1's Physician Orders revealed, coumadin (an anticoagulant (blood thinner)) was ordered to be held and daily PT/INRs drawn and when in normal range restart the coumadin at 5mgs daily. The first PT/INR was drawn on 12/21/23. No documentation could be found in the medical record to ensure the physician orders were followed and the daily labs were drawn. Review of R1's lab results of the first PT/INR drawn on 12/21/23 revealed, PT of 38.8 with the reference interval of 9-11 and an INR of 3.89 with a reference level of 0.89-1.09, indicating both results were High. Review of R1's Medication Administration Record (MAR) revealed, R1 received Coumadin 5mgs daily from 12/18/23 until discharge to the hospital on 12/27/23, with a gastrointestinal bleed due to the medication Coumadin, a blood thinner. During an interview on 04/09/24 at 12:01 PM, the attending Physician stated that once the PT/INR labs resulted, no one called him, so the medication continued and the resident had a gastrointestinal bleed and had to be sent out to the hospital. During an interview on 04/09/24 at 12:43 PM, the Director of Nursing (DON)1 stated, We had orders to draw the PT/INR weekly, and the PT/INR was drawn and no one had access to the results and when they did, the PT/INR was 3.9. During an interview on 04/09/24 at 3:27 PM, the DON2 stated, I would expect the nurses to notify the physician of any abnormal labs and in a timely manner. During an interview on 04/09/24 at 3:35 PM, Licensed Practical Nurse (LPN)1 stated if she had drawn labs she would call the MD (Medical Director) and then document in the nurses notes the values and the fact that she had called the MD with the lab values. During an interview on 04/09/24 at 3:40 PM, Registered Nurse (RN)1 stated, . when the labs are resulted then if they are abnormal I would call the physician and let him know. Then document in the nurses notes the labs and the actions take. During an interview on 04/09/24 at 3:58 PM, LPN2 stated, if the the labs were critical or abnormal she would call the physician and let him know, and then document what the labs were and that I had called the physician.

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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 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. 31846 Based on review of facility policy, record review, and interview, the facility failed to follow best practice, guidelines and procedures to ensure Resident (R)1's attending physician was made aware of elevated lab values that are indicative of and likely to cause bleeding. Furthermore, the facility failed to clarify orders for the use of an anticoagulant after R1's lab values were out of range. The failure resulted in a hospital stay for R1, for 1 of 1 residents reviewed for quality of care. Findings include: Review of the undated facility policy titled Lab and Diagnostic Test - Clinical Protocol revealed, 1. When test results are reported to the facility, a nurse will first review the results. a. If staff who first receive or review lab and diagnostic test results cannot follow the remainder of this procedure for reporting and documenting the results and their implications, another nurse in the facility (supervisor, charge nurse,etc) should follow or coordinate the procedure. 3. A nurse will identify the urgency of communicating with the Attending Physician based on physician request, the seriousness of any abnormality, and the individual's current condition. Identifying Situations that Warrant Immediate Notification . 2. High or toxic serum medication levels. If a test was obtained to monitor the blood level of a medication and the level is reported as high (above therapeutic range) or toxic, the nurse will notify the physician promptly and will not give the next dose until the situation has been reviewed with the physician. Options for Physician Notification .b. Direct voice communication with the physician is the preferred means for presenting any results requiring immediate notification, especially when the resident's clinical status is unstable or current treatment needs review or clarification. Review of R1's Face Sheet revealed the facility admitted R1 on 12/18/23 with diagnoses including, but not limited to: history of aortic valve replacement, atrial fibrillation, and atherosclerotic heart disease. Further review of R1's Face Sheet revealed, R1 was admitted with an INR (international normalized ratio, a type of calculation based on the prothrombin time) of 2.7. Review of R1's Physician Orders revealed, coumadin (an anticoagulant (blood thinner)) was ordered to be held and daily PT/INRs drawn and when in normal range restart the coumadin at 5mgs daily. The first PT/INR was drawn on 12/21/23. No documentation could be found in the medical record to ensure the physician orders were followed and the daily labs were drawn. Review of R1's lab results of the first PT/INR drawn on 12/21/23 revealed, PT of 38.8 with the reference interval of 9-11 and an INR of 3.89 with a reference level of 0.89-1.09, indicating both results were High. Review of R1's [local hospital] Discharge Summary dated 12/18/23, revealed, Hospital Course: . who presented as a trauma consult for mechanical ground level fall while on Coumadin . During hospital course . The patient needs to be evaluated for PT/INR prior restarting Coumadin. Restart Coumadin when appropriated. PT/INR daily prior to restarting Coumadin. Further review of the Discharge Summary revealed, Discharge Meds: Stop taking the following medications: Warfarin (Coumadin) 5 MG TAB. (continued on next page)

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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 0684 Level of Harm - Actual harm Residents Affected - Few	Review of R1's Medication Administration Record (MAR) revealed, R1 received Coumadin 5mgs daily from 12/18/23 until discharge to the hospital on 12/27/23, with a gastrointestinal bleed due to the medication Coumadin, a blood thinner. During an interview on 04/09/24 at 11:15 AM, the Regional Director of Operations (ROD) revealed, during the interview with R1 when R1 returned from the hospital, there were orders to discontinue Coumadin. The Charge Nurse told the ROD that a verbal order was received from the Physician to continue Coumadin and get a Pt/INR level drawn. The ROD stated after speaking with the Physician, the Physician never gave the order but did sign the order. The ROD further stated the resident did received the medication, however they should have looked at the labs and order and questioned the nurse. The ROD concluded this should have been discussed in the morning stand up meeting with clinical staff on returns from the hospital. During an interview on 04/09/24 at 12:01 PM, the attending Physician stated he had not ordered the restart of the Coumadin and he did not give that verbal order. The Physician further stated that once the PT/INR labs resulted, no one called him, so the medication continued and the resident had a gastrointestinal bleed and had to be sent out to the hospital. During an interview on 04/09/24 at 12:18 PM, the Charge Nurse revealed she has the entire conversation with the Physician about restarting the Coumadin. The Charge Nurse stated, He [Physician] told me to restart the 5mgs on 12/18/23. I went on vacation on 12/19/24 and did not come back to work until 12/27/23. The PT/INR was drawn on 12/01/23 and resulted on 12/23/23, but no one called with the result, that I later learned was 3.9. And because of this, the resident had to go back to the hospital. During an interview on 04/09/24 at 12:43 PM, the Director of Nursing (DON)1, who was the DON at the time of the incident, revealed, the resident came from the hospital on 12/18/23, the lab is not connected to the facility and the fax machine did not work. The day [R1] came back from the hospital, the PT/INR was high and held. We had orders to draw the PT/INR weekly, and the PT/INR was drawn and no one had access to the results and when they did, the PT/INR was 3.9. During an interview on 04/09/24 at 3:37 PM, the DON2, who is the current DON, revealed she would expect the nurses to notify the Physician of any abnormal labs in a timely manner.