STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555316	A. Building B. Wing	12/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Copper Ridge Care Center	201 Hartnell Avenue Redding, CA 96002

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49859 Based on interview, record, and policy review, the facility failed to follow physician's orders and complete monitoring and adjustment of warfarin (also called Coumadin, a high-risk medication used to prevent blood clots by thinning the blood and has a significant risk for bleeding complications), for one of four residents sampled for warfarin use (Resident 1), when Licensed Nurse (LN) A incorrectly revised Resident 1's physician's order for a lab test for a prothrombin time and International Normalized Ratio (PT/INR, the laboratory testing parameter utilized to monitor warfarin therapy. The PT is the number of seconds required for the blood to clot, and the INR is the standardized ratio of the PT), and caused the order not to populate on to Resident 1's Electronic Health Record (EHR). This lapse in clinical oversight eliminated opportunities for timely intervention, which could have mitigated the risk of bleeding complications and prevented Resident 1 from enduring serious clinical harm which necessitated emergency treatments and a prolonged 12-day hospitalization . This had the potential to affect all residents who take warfarin. Findings: A review of the facility's policy titled, Anticoagulant [blood thinners] -Clinical Protocol revised November 2018, indicated, a. Assess for any signs or symptoms related to adverse drug reactions due to the medication alone or in combination with other medications. b. Assess for evidence or effects related to the subtherapeutic [less than expected result] or greater than therapeutic drug level related to that particular drug (for example, a resident with an above therapeutic level of an anticoagulation medication should be assessed for bleeding). In addition, the nurse shall assess and document/report the following: a. Current anticoagulation therapy (blood thinning), including drug and current dosage. b. Recent labs, including therapeutic dose monitoring . (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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F 0760 Level of Harm - Actual harm Residents Affected - Few	A review of National Library of Medicine (NIH, a nationally recognized professional resource for healthcare providers), at ncbi.nlm.nih.gov, dated January 2024, indicated; Severe adverse effects of warfarin include bleeding and significant hemorrhage (severe blood loss). Significant hemorrhage, examples of which include intracranial (brain) hemorrhage, gastrointestinal (stomach) bleeding, hematemesis (vomiting blood), intraocular (eye) bleeding, and hemarthrosis (bleeding in a joint), can occur at virtually any body site . Patients should undergo a risk assessment, with appropriate adjustments to their treatment plan made accordingly. Other adverse effects include nausea, vomiting, abdominal pain, bloating, flatulence (gas), and an altered sense of taste .Monitoring: Consistent monitoring of INR levels is essential for all patients receiving warfarin sodium therapy .Patients receiving treatment with warfarin should be closely monitored to ensure the safety and efficacy [desired result] of the medication. Periodic blood testing is recommended to assess the PT and INR .Routine assessment of INR is essential for patients receiving warfarin therapy. The INR of a healthy patient not on anticoagulation therapy is approximately 1.0. Therefore, a patient with an INR of 2.0 or 3.0 requires 2 or 3 times longer for their blood to clot .Most patients receiving warfarin have an INR goal of 2 to 3 .Close INR monitoring is strongly recommended for patients initiating warfarin therapy. This parameter requires more frequent monitoring after beginning a warfarin regimen .More frequent monitoring is necessary for patients with supratherapeutic or subtherapeutic INR to evaluate the safety and efficacy of treatment. Also, the patient's INR requires assessment when initiating, discontinuing, or changing doses . Patients also require close monitoring for signs and symptoms of active bleeding throughout their treatment. Close monitoring for signs and symptoms of bleeding, such as dark, tarry stools, nosebleeds, and hematomas (bruises), is necessary. Toxicity [poisonous]: Warfarin toxicity may be assessed by observing the signs and symptoms of bleeding, as well as the determination of a supratherapeutic INR level. The risk of bleeding is significantly greater for patients with an elevated INR, especially above 5.0. Nurses must recognize the signs of warfarin toxicity so they can alert the attending or prescribing clinician. Review of the facility's policy titled, Medication and Treatment Orders dated July 2016 indicated, 14. Orders for anti-coagulants will be prescribed only with appropriate clinical and laboratory monitoring. Review of admission records for Resident 1 indicated Resident 1 was admitted to the facility on [DATE], with diagnoses that included fracture of right femur (broken hip). A review of a Brief Interview for Mental Status screening (BIMS - an assessment tool used to screen and identify resident memory, orientation, and judgement problems), reflected that Resident 1 scored 12 out of 15, which indicated that she had good memory and ability to make decisions. A review of Resident 1's Physician's Orders, dated for the month of September 2024, was conducted and reflected the following: On 9/5/24, Resident 1's Attending Physician (AP), ordered warfarin 3.5 milligrams (mg, a unit of measure) to be given once a day and to check her PT/INR by lab testing, on 9/6/24. On 9/7/24, AP increased Resident 1's warfarin to 5 mg once a day and ordered to recheck her PT/INR on 9/9/24. On 9/9/24, AP increased Resident 1's warfarin to 7.5 mg once a day and ordered to recheck her PT/INR on 9/12/24. (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	On 9/13/24, AP increased Resident 1's warfarin to 9 mg once a day and to recheck her PT/INR on 9/16/24. A review of Resident 1's PT/INR lab testing results for the months of September and October 2024, was conducted and reflected the following: On 9/6/24, the PT was 17 and the INR 1.4. On 9/9/24, the PT was 17.4 and the INR 1.4 On 9/12/24, the PT was 18.9 and the INR 1.6 There was no evidence that the PT/INR lab test was done on 9/16/24. On 9/30/24, a PT/INR was done and the results were too high for the laboratory equipment to analyze. On 10/1/24, a PT/INR was done and Resident 1's PT was greater than 120 and her INR was greater than 16 (a critical lab result). A review of Resident 1's Progress Notes for September and October 2024, was conducted and documentation reflected the following; On 9/28/24, Resident 1 had blood in her urine. On 9/29/24, at 5:55 AM, Resident 1 complained of nausea and vomiting, she didn ' t feel like eating, had not eaten much the night before, had mostly drank water that day and had only soup for dinner the night before. At 10:25 AM, Resident 1 complained of left abdomen pain, she had the urge to urinate and could not. Resident 1 had not eaten much and had only eaten one yogurt and half of a banana for breakfast. At 6:10 PM, Resident 1 had blood in her urine and was having difficulty urinating and pain in her left side. At 8:15 PM, a urine sample was collected from Resident 1 for a urinalysis (UA, a test done on urine to check for signs of infection), and the urine was bloody. A review was conducted of Resident 1's Lab Results Report for the UA dated 9/29/24 at 10:06 PM, and indicated, Unable to perform chemical analysis due to color interference caused by the grossly [extremely obvious just by looking at it] bloody specimen received. A review of Resident 1's Progress Notes dated 9/30/24, nursing documentation showed that at 8:51 AM, Resident 1 reported nausea and vomiting. At 9:01 AM, an order was obtained for a PT/INR to be done which was done at 12:53 PM. At 2:55 PM, lab called stated the PT/INR level was so high it could not be read. At 3:48 PM, the Physician's Assistant (PA) was notified and ordered Vitamin K (a medication that reverses the effects of too much warfarin and helps the blood clot), 1 Gram, hold warfarin for 3 days, and do a PT/INR daily for 3 days. At 5:09 PM, another UA was collected from Resident 1 and sent to the lab and the urine was noted by the nurse to be tinted red. (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	A review of Resident 1's Lab Results Report dated 10/1/24, indicated a PT of greater than 120 seconds (PT greater than 27 is a critical value and indicates an increased risk of bleeding), and an INR of greater than 16 (INR greater than 5 is a critical value and indicates an increased risk of bleeding). A review of Resident 1's Progress Notes dated 10/1/24, reflected at 11:43 AM the nurse received a phone call with critical labs of an INR greater than 16. At 12:31 PM, a new order was obtained from the PA for Vitamin K 2.5 milligrams (mg, a unit of measure) by mouth one time. At 11:07 PM, Resident 1 stated she was nauseated and the Zofran (a medication for nausea), was not helping her. A review of Resident 1's Progress Notes dated 10/2/24 reflected at 1:02 PM, a nurse documented that the facility received a phone call from the lab reporting Resident 1's PT/INR was still critical with a PT greater than 120 and INR greater than 16. At 2:23 PM, nursing documentation reflected that Resident 1 requested to be sent to the hospital and was transferred to the hospital by ambulance at 2:25 PM. A review of Resident 1's, SNF/NF to Hospital Transfer Form dated 10/2/24 at 1:45 PM reflected that Resident 1 was on warfarin and her last INR was done on 10/2/24 and was critical at greater than 16. Under the GU/Urine [the urinary and bladder system] Evaluation the box blood in urine was checked. A review of Resident 1's hospital emergency room [ER] documentation, dated 10/2/24, reflected that the physician's preliminary concerns were that Resident 1 had a spontaneous retroperitoneal hematoma (internal bleeding around the kidneys), the high INR, acute kidney injury (a condition in which the kidneys suddenly can't filter waste from the blood), and possible sepsis (a life-threatening blood infection) related to a urinary tract infection (UTI, an infection of any part of the urinary system) and low urine output. A Computed Tomography scan (a CT scan is a medical imaging procedure that uses x-rays to make detailed images of the body), of Resident 1's abdomen and pelvis was done and indicated fluid that was suspicious for internal bleeding. A review of Resident 1's hospital History and Physical dated 10/2/24, reflected that Resident 1's lab testing at the ER showed a PT greater than 120 and an INR of greater than 12 (both critical). The physician documented that Resident 1 had, warfarin coagulopathy (a bleeding complication due to too much warfarin in the blood stream), which caused blood in her urine and internal bleeding around her kidneys and upper ureters (thin tubes that connect the kidneys to the bladder). Resident 1 was given Kcentra (a medication given for urgent reversal of warfarin overdose), and Vitamin K. A review of Resident 1's, Hospital Record Progress Notes dated 10/2/24, reflected diagnoses of internal bleeding around the kidneys, high INR, Acute Kidney Injury (AKI), metabolic acidosis (the buildup of acid in the body due to kidney disease or kidney failure), and diabetes insipidus (a condition that causes the body to make large amounts of urine and excessive thirst and causes the fluids in the body to be out of balance). During an interview on 11/26/24 at 2:50 PM, with the Medical Director (MD), the MD stated that when the warfarin dosage is being adjusted there should be PT/INR monitoring in about 2 days. (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	During an interview on 11/26/24 at 3:09 PM, with PA, the PA indicated Resident 1's PT/INR lab test, that was ordered for 9/16/24, may have been missed due to the order being put in the wrong place in Resident 1's EHR. The PA indicated that her understanding was that there were two places lab orders could be within a resident's EHR. The PA indicated the Attending Physician (AP) hand writes the orders directly on the lab results report and faxes it back to the nurses. The nurses would then enter any new orders into the residents EHR. During an interview on 11/26/24 at 3:15 PM, with the Director of Nursing (DON), the DON stated that she was not sure what caused the PT/INR to not populate on Resident 1's EHR, after LN A revised the order. The DON confirmed that the order was not in Resident 1's EHR and the PT/INR was not done. The DON indicated she caught this 14 days later, after Resident 1 began having active bleeding, it was an oversight. During an interview on 12/5/24 at 2:51 PM, with the PA, the PA confirmed she saw Resident 1 on 9/25/24, and had not recognized that the PT/INR, that was to be done on 9/16/24, was missed. A review of Resident 1's Progress Notes dated 9/25/24, reflected that PA saw Resident 1 on 9/25/24 and made a note that Resident 1 was taking warfarin, but had not addressed that the PT/INR that was ordered by AP to be done on 9/16/24, had not been done. During an interview on 12/5/24 at 3:29 PM, with the DON, the DON stated that nurses enter physician's orders into the EHR LAB flow sheet, and from there every night a nurse runs a report for lab tests that are to be done for that day. The nurse then filled out lab requisition (request) form which indicated what lab tests were to be done each day. The DON stated that if the physician's orders do not make it on to the LAB flow sheet, the labs may not show up on the report thererfore, will not likely get done. During an interview on 12/6/24 at 11:36 AM, with the MD, the MD stated that acute retroperitoneal hemorrhage is very common complication when too much warfarin is taken and PT/INRs are too high. The MD stated that after a review the PT/INR lab results, a physician would be expected to give orders to the nurses that would include; when to get the next PT/INR, change or hold the warfarin dose, either verbally (in person or on the phone), or by handwritten orders directly on the lab result sheet and faxed to the nurse. The nurses would then enter the physician's order into the resident's EHR. During an interview on 12/11/24 at 9:05 AM, with Resident 1, Resident 1 indicated that the nurses had not listened to her when she told them she had been sick for days, so she asked to be sent to the hospital. Resident 1 stated, I was bleeding from my mouth, nose, and vagina, and it was very much a nightmare and I felt like I was dying. During an interview on 12/12/24 at 1:12 PM, with LN A, LN A indicated that Resident 1's PT/INR lab testing order that was to be done on 9/16/24, was on the wrong MAR. LN A indicated that there were MARs for medications and different MARs for Lab testing. LN A indicated that her intention was to move the PT/INR lab test order from the medication MAR to the lab MAR, and had not recognized that the order never made it to the lab MAR. LN A indicated that she does not know how that happened. During an interview on 12/12/24 at 3:59 PM, with the Assistant Director of Nursing (ADON), the ADON confirmed that nursing staff received training on the facility's EHR system upon hire and and when any changes to the system occur.