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	345223	A. BUILDING _____ B. WING _____	C 02/19/2014

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 254 SS=E	483.15(h)(3) CLEAN BED/BATH LINENS IN GOOD CONDITION The facility must provide clean bed and bath linens that are in good condition. This REQUIREMENT is not met as evidenced by: Based on observations, review of facility records and staff, resident and family interviews, the facility failed to provide an adequate supply of washcloths, towels and incontinence pads for use on 2 of 3 units (East and West halls). The findings included: Observation on 02/17/14 at 10:50 AM of the 100 hall linen closet revealed no wash cloths, towels or incontinence pads were available. A nursing assistant present in the linen closet at the time of the observation stated staff use folded blankets or sheets for incontinence pads. This staff member also noted that if towels or wash cloths were not available in the linen closet staff went to the laundry to obtain them. Observation on 02/18/14 at 5:30 PM of the 200 Hall linen closet revealed 9 towels, a small stack of wash cloths and no incontinence pads were available. Observations on 02/19/14 at 9:37 AM and 9:55 AM of the 100 Hall linen closet revealed no washcloths or towels available for use and no incontinence pads were available. Observation on 02/19/14 at 11:05 AM of the 200 Hall linen closet revealed 6 washcloths and 2 bath towels available for use and no incontinence pads were available for use. Observation of Resident #2 on 02/18/14 at 2:25 PM and on 02/19/14 at 2:27 PM revealed a	F 254	Preparation and or the execution of he plan of correction does not constitutes admission or agreement by the provider of the truth of facts alleged or the conclusion set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. DHSR NH L&C Black Mountain WRO Received MAR 27 2014 by: SKH F254 A 100% audit of linens were performed and linens were ordered. Laundry Supervisor will provide the Administrator with a linen inventory monthly. The laundry supervisor or designee will audit the clean linen closet three times daily to assure all shifts have sufficient linens. The nursing staff will be re-educated on the utilization of proper incontinence care products. Disposable care pads will be used for residents who utilize a low air loss mattress. DHSR NH L&C Black Mountain WRO Received MAR 31 2014 by: SKH	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Executive Director — (X6) DATE: 3/25/14

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.

Original Signature: 3-11-14

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multi-folded sheet underneath the resident's buttocks being used as an incontinence pad.

Observation of Resident #6 on 02/17/14 at 1:40 PM revealed a multi-folded blanket underneath him being used as an incontinence pad. Observation of Resident #6 on 02/19/14 at 9:15 AM revealed a multi-folded sheet being used as an incontinence pad.

An interview on 02/17/14 at 11:58 AM with a family member of Resident #4 revealed there had been occasions recently when washcloths were not available in the linen closet on 200 Hall.

An interview on 02/17/14 at 1:40 PM with the Director of Nursing (DON) revealed the facility only used reusable incontinence pads for a few residents who requested them but otherwise used disposable briefs.

An interview on 02/17/14 at 2:23 PM with Nurse Aide (NA) #1 about the availability of towels, washcloths and incontinence pads revealed there were hardly ever any incontinence pads available for use. NA #1 reported there were times when there were no washcloths available and she had cut up a towel to make washcloths.

An interview on 02/18/14 at 1:40 PM with Resident # 5 revealed she didn't think there were enough towels
and washcloths. Resident #5 stated she had seen staff throw away towels and washcloths after providing incontinence care for her. Resident #5 stated she had told the last Administrator that staff were
throwing the towels and washcloths away.

F 254 The remaining residents who are incontinent will use a brief and a single folded draw sheet while i n bed. 100% audit will be performed to determine whether other residents have been affected and the correct products are being utilized, then five patients a day will be audited for two months and then two daily for an additional three months, by Director of Nursing/designee. The results of the audits will be reviewed by the Administrator and the results will be reported at the QA meeting.
Patient #2 was assessed by Director of Nursing. Disposable pads were ordered and received. Dir. of Nursing/Designee will continue to monitor for the effectiveness of the new product.
Patients #6 The patient was assessed for proper incontinence care products.
The patient's chair was cleaned. The staff will be re-educated on the incontinence care protocol. The patient will be monitored daily by Dir. of Nursing /designee to ensure compliance.
Patient # 5 A 100% audit was performed and linen was ordered. Audits will be performed and reported at QA meetings as stated above.

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An interview on 02/18/14 at 5:30 PM with NA #4 about the availability of towels and washcloths revealed there were frequently times when there were not towels and washcloths available. When asked what she did when she didn't have them available to do resident care, she stated she just had to wait till they were available from laundry.

An interview on 02/19/14 at 9:55 AM with NA #3 revealed there were frequently times when there were not towels and washcloths available. NA #3 reported when there were not towels or wash cloths available she would go to the laundry to find some for resident use.

In an interview on 02/19/14 at 10:10 AM with the DON, the DON was asked if she was aware there was a problem with towels and washcloths not being available and she stated she was aware there was a problem. She stated the facility had ordered towels and washcloths several times but they were short again. The DON stated when staff tell her they are out of towels or washcloths, she checks with the laundry to see if there are any available and takes them to the staff.

An interview on 02/19/14 at 1:55 PM with the Laundry Supervisor (LS) revealed laundry services were provided at the facility through a contractual agreement that had been in place for the past 7 months. The LS stated the services did not include ordering new linen. She stated she gave the administrator an inventory of all supplies every month so the facility could determine what items needed to be purchased. The LS stated new linen had been ordered 3 times in the past 7 months, including towels and washcloths in the past week. The LS stated 2 laundry aides worked every day from 7:00 AM to 3:00 PM and 1 laundry

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aide worked from 2:00 PM to 10:00 PM. She stated linen was delivered to the nursing units 4 times a shift on the day and evening shifts. The LS stated there were only a few non-disposable pads in the facility. At the time of the interview 5 non-disposable pads were located in the 200 hall linen closet. The LS stated she could tell staff were using bed sheets for incontinence pads because of how soiled they were when they were brought to the laundry. The LS stated she had been told the facility did not use incontinence pads.

During an interview on 02/19/14 at 3:00 PM with the Administrator, he was asked if he was aware that there were instances when no washcloths were available for use when needed. The Administrator stated he had received occasional complaints about the facility not having enough washcloths and he had ordered washcloths. When asked about the availability of incontinence pads, he stated he wasn't aware the facility had any incontinence pads and had not seen any in use. He stated he thought there was a corporate policy about not using incontinence pads. When asked if it was acceptable for staff to use folded sheets and blankets as incontinence pads, he stated staff should not be using folded sheets and blankets as incontinence pads. He stated if staff were going to use folded sheets and blankets the facility needed to get incontinence pads.

An additional interview with the Administrator and Nurse Consultant on 02/19/14 at 6:31 PM revealed the corporation who owns the facility issued a directive 10 years ago stating they didn't want incontinence pad of any type used because they felt the incontinence briefs with the new technology kept more moisture away from the

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resident's skin than lying on a wet pad. The Nurse Consultant stated facility staff can assess individual residents for the use of incontinence pads and use them for specific residents if they determine the resident needs them.

F 309 SS=D 483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING

Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.

This REQUIREMENT is not met as evidenced by:
Based on observations, record review and staff interview, the facility failed to assess 5 new stage 2 wounds in a resident with an existing open wound, who was identified as being at high risk of further skin breakdown, for 1 of 3 sampled residents (Resident # 2).

The findings included:

Resident #2 was admitted to the facility on 02/25/13 with diagnoses which included chronic obstructive pulmonary disease, diabetes mellitus type 2, congestive heart failure and chronic ulcer and atony of bladder.

The most recent assessment was an annual Minimum Data Set (MDS) dated 01/20/14 which indicated Resident #2 was cognitively intact for daily decision making and had no behavioral

F 309

F309
A 100% skin audit will be performed by the Assistant Director of Nursing/designee. The nursing staff will be re-educated to report new areas immediately to the charge nurse and the proper usage of the Body Assessment Tool and the proper reporting of skin breakdown per the Golden Living Skin Integrity Guidelines. Nurses will generate a Golden Livings DQI (Data for Quality improvement) / incident report for newly developed skin break down and will be reviewed in the clinical "start up" meeting. The charge nurse will notify the patient's doctor and begin the treatment as the doctor orders. The Dir. of Nursing/designee will audit and observe wound care weekly. Patients identified as "High Risk " will be monitored to prevent skin breakdown and proper interventions will be put into place and discussed weekly at the "At Risk" meeting. The wound nurse will be re-educated on the proper staging of wounds and Skin Integrity through the use of The Golden University and The Skin Integrity Guidelines proper documentation.

3-19-14

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symptoms or rejection of care. The MDS further indicated Resident #2 required extensive assistance from staff with bed mobility, locomotion on the unit, dressing, toilet use and personal hygiene. She was totally dependent on staff for transfers, locomotion off the unit and bathing. The MDS indicated she had an indwelling catheter and was always incontinent of bowel. She was assessed as being at risk of developing pressure ulcers, had a pressure reducing device for her bed and nutrition or hydration intervention to manage skin problems. The MDS indicated she did not have an unhealed pressure ulcer but did have moisture associated damage and had application of ointments or medications in areas other than her feet.

The Care Area Assessment (CAA) Summary for pressure ulcers dated 01/20/14 indicated Resident #2 was at risk for pressure ulcers due to the risk factors of impaired mobility, medical diagnosis, incontinence and medication use. Resident #2 was required assistance with all activities of daily living (ADL). The decision was to proceed to care plan to minimize risk factors and to ensure resident skin remained intact and treatment of new skin issues would be addressed as needed through the next review.

The Care Plan indicated the resident was at risk of pressure ulcers due to a history of pressure ulcers on bilateral posterior thighs, obesity, diabetes and decreased mobility. The stated goal was "skin will remain intact." Included in the interventions was weekly skin assessments to be done according to facility policy.

Further review of Resident #2's medical record revealed a nurse's note dated 01/10/14 at 1:12

A competency test will be performed by the wound care nurse and will be tested by the Director of Clinical Education. Patient #2 wound will be assessed and the proper treatment will be put into place. The Dir. of Nursing will monitor patient #2's wound weekly until the wound is resolved. The Director of Nursing/designee will seek a consult with the Wound Doctor to re-evaluate the skin products currently being used on patient #2 and we will follow the Doctor's recommendation. 3-19-14

The Dir. of Nursing /designee will audit any newly identified skin areas and will audit two pre-existing wounds a week to insure protocols are being followed for two months and one patient a week for one month and one patient a month for two months. A QAPI will be initiated and reported at the monthly QA meeting..

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PM which indicated resident had a macerated area on her right upper posterior thigh which measured 1.2 cm (centimeters) X 7.0 cm X 0.1 cm. She was being seen by the wound care physician and the area was being treated with calmoseptine, a moisture barrier and medicated cream. The note further indicated Resident #2 was on an air mattress and was repositioned frequently but was unable to remain on her side for extended periods of time due to breathing difficulty. A nurse's note dated 02/17/14 at 2:45 PM read in part: "spoke with FNP (family nurse practitioner), treatment to buttocks/thigh areas changed to MediHoney. Areas continue related to moisture induced maceration. Calmoseptine would not stay on resident's skin."

Review of a progress note by the wound care physician dated 01/06/14 indicated Resident #2 had a pressure ulcer on the right upper posterior thigh which he assessed as being a stage 2 wound which measured 1.2 cm X 0.7 cm X 0.1 cm and the periwound was macerated. The note indicated the current treatment was Calmoseptine and the area was improving. A progress note by the same physician dated 02/03/14 indicated the treatment remained the same and the area was deteriorating with the measurement of the wound being 8.2 cm X 7.1 cm X 0.1 cm. The note also indicated the resident had more open areas on the right upper posterior thigh and she remained very difficult to reposition due to extreme obesity and reluctance to leave her bed. The physician indicated : "this is likely to be a lifelong problem and will make healing of this wound very difficult. Patient advised of need to comply with wound treatment for wound to heal."

Additional review of Resident #2's medical record

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did not reveal any assessment or measurements of Resident #2's Moisture Associated Skin Deterioration (MASD) areas after the 01/10/14 nurse's note. The nurses notes from 12/21/13 through 02/17/14 referred to open areas on bilateral buttocks but no assessments of the wounds was available.

Review of the physician's orders revealed an order dated 12/09/13 to clean right upper posterior thigh with wound cleanser and apply Calmoseptine cream twice a day and as needed for soiling. An order dated 02/17/14 discontinued the Calmoseptine and indicated the wounds were to be cleaned with wound cleanser twice a day and MediHoney applied.

During the initial tour on 02/17/14 at 10:49 AM, Resident #2 was observed lying on her back in an alternating pressure, low air loss bed. She expressed concern that her bottom wasn't healing.

Subsequent observations on 02/17/14 at 12:00 PM, 02/18/14 at 10:00 AM, 1:55 PM and 3:40 PM, 02/19/14 at 11:10 AM and 2:17 PM revealed resident lying on her back on an alternating pressure, low air loss mattress. Resident #2 was observed raising and lowering the head of the bed and stated that was the only way she could change positions. She stated she had trouble breathing when she was on her side.

Observation of wound care being provided to Resident #2 on 02/17/14 at 2:45 PM revealed the presence of 3 full thickness open wounds on the right upper posterior thigh and 3 full thickness open wounds on the left buttock. Nurse #4 measured the wounds when wound care was

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provided on 02/18/14 at 2:25 PM. The measurements of the areas were as follows: left buttock #1 - 0.4 cm X 0.5 cm X <0.1 cm; left buttock #2 - 2.0 cm X 2.7 cm X <0.1 cm; left buttock #3 - 0.7 cm X 1.7 cm X < 0.1 cm; right posterior thigh #1 - 5.5 cm X 4.9 cm X <0.1 cm; right posterior thigh #2 - 7.6 cm X 1.4 cm X 0.2 cm; right posterior thigh #3 - 9.3 cm X 1.6 cm X 0.2 cm.

An interview on 02/18/14 at 9:30 AM with Nurse #4, who was the nurse responsible for completing weekly assessments of all residents with pressure ulcers, revealed that she didn't think it was necessary to measure the area on Resident #2's right upper posterior thigh because the breakdown was due to moisture instead of pressure. Nurse #4 stated she assisted with the wound treatment on 02/15/14 and the resident only had one main open area on the right upper posterior thigh.

An interview with the Director of Nursing (DON) on 02/18/14 at 10:10 AM revealed she had not seen the resident's wounds in a couple of weeks and thought they were mostly better.

An interview with the DON on 02/19/14 at 10:10 AM revealed every resident should have a weekly body audit with a nurse's note that is assigned by shifts for different days of the week. She stated the nurses document on the body audit sheet if there's any skin breakdown. According to the information provided by the DON, Resident #2 was scheduled for a weekly body audit every Saturday by the nurse working the 3:00 PM - 11:00 PM shift. When asked if there was any additional information after the 01/10/14 nurse's note, she provided a weekly body audit sheet with

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F 309	Continued From page 9 an entry dated 02/08/14 and 02/15/14 which indicated treatment was ongoing to buttock and the nurse's signature. She could offer no explanation for there not being any measurements of the area.	F 309		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interview the facility failed to provide incontinence care for a resident who was always incontinent of bowel and bladder and required extensive assistance from staff with activities of daily living (ADL) for 1 of 2 sampled residents observed for incontinence care (Resident # 6). The findings included: Resident #6 was admitted to the facility on 11/14/12 with diagnoses which included dementia with behavioral disturbances, atrial fibrillation, congestive heart failure and hypertension. His most recent assessment was a quarterly Minimum Data Set (MDS) dated 01/06/14 which indicated the resident was always incontinent of bowel and bladder and required extensive assistance with bed mobility, transfers, dressing, toilet use and personal hygiene. His comprehensive care plan, which was most	F 312	F312 All nursing staff will be re-educated on the proper incontinence guidelines by using the Clinical Guidelines for Incontinence. Residents will be checked at regular intervals as needed to maintain the highest level of bowel and bladder function. The Dir. of Nursing/designee will audit five incontinent patients a day for two months and then two daily for two additional months to ensure residents are being changed in a timely manner.. A bowel and a bladder log will be followed on patient #6 for 72 hours to determine voiding habits and staff will continue to monitor patient for any incontinence issues. An ongoing QAPI will be performed and reported at the monthly QA meeting.	3-19-14

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recently updated on 01/13/14, addressed his need for extensive assistance with most ADL. The stated goal was that resident would be clean, dry, well-groomed and appropriately dressed through the next review. Included in the approaches was: check frequently, provide peri-care after incontinence episodes; Resident wears adult briefs. The care plan also addressed Resident #6's risk for urinary tract infections (UTI) due to incontinence. The stated goal was that resident would remain free of UTI. Included in the approaches was: assist with toileting or incontinence care as needed.

During a resident interview on 02/17/14 at 12:10 PM Resident #6 requested that surveyor call the Veteran's Administration Medical Center (VA) because he was "passing blood." When a nurse entered his room at 12:15 PM he told the nurse that he was passing blood out of his rear end.

On 02/17/14 at 1:40 PM Nurse Aide (NA) #1 and NA #2 were observed providing incontinence care to Resident #6. The NAs used a mechanical lift to assist Resident #6 into a standing position. He was wearing thick, dark gray jogging pants which were visibly wet in front and back and down the inside of both legs. A folded blanket upon which the resident had been sitting was wet through all layers and the seat of the recliner underneath the blanket was wet. When staff removed the adult incontinence brief which the resident was wearing it was saturated. There was no blood noted on the brief and no signs of active rectal bleeding. When staff had completed the incontinence care, the resident stated: "I'm a nervous wreck."

An interview with NA #1 on 02/17/14 at 1:50 PM, following completion of the incontinence care,

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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revealed she had last provided incontinence care to Resident #6 at 10:00 AM. When asked about using a folded blanket in the recliner, she stated they didn't have many incontinence pads so she just used a folded towel or blanket because "he's a heavy wetter."

An additional interview with NA #1 on 02/17/14 at 2:23 PM about how often she was expected to check residents who were incontinent revealed she was supposed to check them every 2 hours. When asked if Resident #6 was able to tell her when he was wet, she stated: "He doesn't say anything the first time he pees; he doesn't say anything until he's really, really wet." She stated he needed checked more frequently than every 2 hours but she didn't always have time to check him more often.

Observation of Resident #6 on 02/19/14 at 9:15 AM revealed resident in bed with his eyes closed and he appeared to be asleep. He was covered with blankets positioned in such a way that part of his adult incontinence brief was visible as well as a multi-folded sheet upon which he was laying. He smelled of urine.

Observation on 02/19/14 at 9:30 AM of NA #3 providing incontinence care revealed the incontinence brief worn by Resident #6 was saturated and the folded sheet which was underneath the resident was wet through all 8 layers. There was a strong odor of urine in the room.

An interview with NA #3 on 02/19/14 at 9:55 AM revealed she came on duty at 7:00 AM and the first time she had provided incontinence care to Resident #6 was at 9:30 AM.

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An interview with the Director of Nursing (DON) on 02/19/14 at 10:10 AM about her expectation for checking residents and providing incontinence care revealed she expected residents who were incontinent to provided incontinence care at least every 2 hours.

An interview with the Administrator on 02/19/14 at 3:00 PM about the use of folded sheets and blankets under residents as incontinence pads revealed staff should not be using folded sheets and blankets. He stated if staff were going to do that, the facility needed to get pads. When asked about his expectation for incontinence care, he stated it was unacceptable for a resident to be as wet as Resident #6 was during both observations. He stated the resident should have been changed more often.

F 313 SS=D — 483.25(b) TREATMENT/DEVICES TO MAINTAIN HEARING/VISION — F 313

To ensure that residents receive proper treatment and assistive devices to maintain vision and hearing abilities, the facility must, if necessary, assist the resident in making appointments, and by arranging for transportation to and from the office of a practitioner specializing in the treatment of vision or hearing impairment or the office of a professional specializing in the provision of vision or hearing assistive devices.

This REQUIREMENT is not met as evidenced by:
Based on observations, record review and interviews with resident and staff the facility failed to provide corrective lenses for 1 of 1 resident

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reviewed for assistive devices to maintain vision (Resident # 7).

The findings included:

Resident #7 was admitted to the facility on 06/17/12 with diagnoses which included diabetes mellitus type 2, hypertension and dementia. The most recent assessment was a quarterly Minimum Data Set (MDS) which assessed the resident as cognitively intact for daily decision making. The MDS indicated her vision was adequate with corrective lenses. The MDS indicated the resident had no delirium, psychosis or behavioral symptoms. The most recent comprehensive care plan did not address the resident's need for glasses. The care guide used by the Nurse Aides did not indicate Resident #7 wore glasses.

During the initial tour of the facility on 02/17/14 at 10:41 AM, Resident #7 reported that several months ago she lost her glasses. She stated during that time she had been in the hospital so she didn't know if the glasses got lost at the hospital or at the facility. She stated she had an eye exam shortly after losing her glasses but still had not received her glasses. She stated: "I really need them. I can't see how to read without them."

Review of an optometrist's note dated 09/26/13 revealed an order for corrective lenses.

An interview on 02/18/14 at 10:30 AM with Social Worker (SW)#1 confirmed Resident #7 had an eye exam on 09/26/13 and the glasses were ordered a few days later. She stated the facility mailed a check to the optometrist on 10/24/13. SW #1 stated she checked with the optometrist

F313
All items ordered for patients will be logged in the "Special requested items " Log Book" maintained by the Social Service Department. The log will be reviewed weekly at the "Stand-up Meeting" to ensure residents are receiving the items ordered for them in a timely manner. An audit will be performed by the Administrator/designee. The Business Office Manager and Social Service staff will be educated on the new process by the Social Service Director/ designee. An ongoing QA of the "Log Book" will be performed by Social Service Director/designee, to ensure residents are receiving their ordered items timely. Resident # 7 glasses have been ordered and Eye doctor has requested a rush on the order. We will review glass order weekly and follow up until glasses are received by patient.

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on 02/18/14 and was told the check for the glasses had not been received. SW #1 stated she notified the Business Office Manager (BOM) on 02/18/14 and she wrote another check which SW #1 personally delivered to the optometrist on 02/18/14. She stated the optometrist put a rush order on the glasses and thought they would be delivered to the facility in less than 2 weeks. SW #1 stated she wished she had known Resident #7 had not received her glasses and she would have checked on why they hadn't been delivered.

An interview on 02/18/14 at 1:35 PM with Resident #7 revealed she had asked several staff members about her glasses but couldn't recall who she had asked. She stated she talked to SW # 1 earlier in the day and was told she would get her glasses in less than 2 weeks.

An interview on 02/19/14 at 9:10 AM with SW #1 about the facility's process for obtaining glasses for residents who needed them revealed the first step was to schedule the resident to see the optometrist who came to the facility to see residents. If the optometrist determined the resident needed glasses, she gave an order for the glasses to SW #1 which she gave to the BOM. She stated the BOM then contacted the Department of Social Services (DSS) case worker in the resident's county of residence to request funds to pay for the glasses. SW #1 stated it usually took about a month to get the money to pay for the glasses. She stated when the BOM received the money she mailed a check to the optometrist. When the optometrist received the glasses a staff member from the optometrist office delivered the glasses to the resident at the facility to make sure they fit properly. When asked what the facility's system was for ensuring

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F 313	Continued From page 15 the glasses were received and whether there was any type of log, she stated: "We haven't but we will now." An interview on 02/19/14 at 9:45 AM with the BOM revealed documentation that payment for the glasses was sent to the optometrist on 10/17/13. An interview on 02/19/14 at 11:24 AM with Social Worker #2 revealed Resident #7's daughter asked about her glasses about 2 months ago and the resident asked about her glasses about a month ago. She stated she asked the BOM or SW #1 about them but couldn't recall which one. She stated she thought Resident #7 had gotten her glasses because she hadn't asked her about them again. An interview on 02/19/14 at 3:00 PM with the Administrator revealed he felt there was no excuse for Resident # 7 not receiving her glasses.	F 313		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced	F314	3-19-14 F314 All licensed nurses will be re-educated using the Golden Living Clinical Guidelines Patient #6's foot was reassessed and proper footwear was ordered. The old footwear was removed. All current residents with pressure ulcers will be assessed for proper equipment and positioning devices, by the wound care nurse/designee. All future residents when admitted with pressure ulcers will be assessed by the wound care nurse/designee. All residents with pressure ulcers are discussed at the	

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by:
Based on medical record review, observations and staff interviews the facility failed to assess 1 of 1 sampled resident with a heel pressure sore for appropriate footwear to promote healing. (Resident #6)

The findings included:

The facility policy for pressure sores which was last updated 2013 included, if a resident is identified at risk or with actual alterations in skin integrity of feet, footwear will be addressed for appropriateness.

Resident #6 was admitted to the facility 11/14/12 with diagnoses which included dementia with behavioral disturbances, depression, anxiety, psychosis, peripheral vascular disease, episodic mood disorder, atrial fibrillation, congestive heart failure, hyperlipidemia and hypertension. The last Minimum Data Set assessment completed 01/06/14 indicated Resident #6 had impaired cognition as well as poor short and long term memory and one, stage III pressure sore.

The last Care Area Assessment (CAA) for Resident #6 was completed 11/25/13 with an annual assessment. This assessment of pressure sores included, (Resident's name) is at risk for pressure ulcers. He currently has a stage III on his left heel that is undergoing pressure ulcer treatment. Contributing factors include impaired cognition, impaired mobility, incontinence and medication use. Will proceed with care plan to minimize risk factors and to ensure resident skin remains intact and treatment of new skin issues will be addressed as needed through next review.

weekly "At Risk", meeting. The Dir. of Nursing/designee will audit the equipment and positioning devices of residents with pressure ulcers. Two residents will be audited weekly for two months, then one resident shall be audited weekly for one month, then one resident a month for two months. An ongoing QAPI will be performed and discussed at the monthly QA meeting to assure residents with pressure ulcers have the proper pressure relieving devices in place.

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The current care plan for Resident #6 was last updated 01/13/14 and included a problem area, Admitted with unstageable area to left heel. Potential further altered skin integrity related to incontinence and limited mobility. The goal to this problem area was to have no further skin breakdown through next review. Approaches to this problem area included: provide pressure reducing wheelchair cushion and mattress. The care guide utilized by nursing assistants to know the individual needs of residents included the use of the pressure reducing wheelchair cushion and mattress for Resident #6. The care guide did not include any instructions for footwear for Resident #6.

Treatment orders for Resident #6 noted the last order was changed 01/13/14 for, "Wound care left heel. Cleanse with normal saline. Apply Alginate with Ag, cover with gauze and tape every day and as needed soiling."

The latest assessment of the left heel pressure sore for Resident #6 by the wound care center assessed it as follows: 2.8 centimeters (cm) X 2.2 cm X 0.2 cm, unhealthy/inadequate granulation, excessive necrotic tissue with mild sero-sanguinous drainage. The wound was assessed as a Stage III by the wound physician.

Resident #6 was observed on 02/17/14 from 3:00 PM-4:40 PM. Resident #6 had hard athletic style shoes on both feet and was seated in a wheelchair with his legs in a dependent position. Leg rests were observed on the wheelchair and Resident #6 utilized his hands to propel the wheelchair throughout the hallways of the facility. Resident #6 was observed on 02/18/14 at 10:00

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AM, 10:15 AM, 10:50 AM, 11:20 AM, 12:15 AM, 12:45 PM, 1:00 PM, 1:30 PM with the same hard athletic style shoes on both feet. On 02/18/14 at 1:30 PM the left ankle and foot of Resident #6 appeared swollen and red. Resident #6 was seated in a wheelchair with his legs in a dependent position and both feet resting on footrests. On 02/18/14 at 1:55 PM Nurse #3 was observed during treatment of the left heel pressure sore of Resident #6. At the start of the treatment the hard athletic style shoe was taken off the left foot of Resident #6. Nurse #3 then removed a white sock off the left foot of Resident #6. A large, approximate four inch in diameter circle of sero-sanguinous drainage was noted on the area of the sock where the heel of Resident #6 would be positioned. Upon questioning, Nurse #3 stated the hard athletic style shoes were put on Resident #6 because it was his preference. Nurse #3 stated there had been a time when slipper style shoes had been tried on Resident #6 but could not recall when they were last tried. After the treatment was completed on Resident #6, Nurse #3 asked if he would consider wearing non-slip socks. Resident #6 agreed to try the non-slip socks noting his foot hurt. The non-slip socks were placed on both the right and left foot of Resident #6 and he noted, they feel a whole lot better. Observations on 02/18/14 at 2:55 PM and 5:15 PM noted the non-slip socks remained on Resident #6. At 5:15 PM Resident #6 stated he liked the socks.
On 02/19/14 at 11:15 AM, 12:35 PM, 2:30 PM and 5:15 PM Resident #6 was observed in his room, seated in a recliner with socks on both his right and left foot.

On 02/18/14 at 4:20 PM the Director of Nursing (DON) stated when Resident #6 was admitted

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F 314	Continued From page 19 (11/14/12) attempts had been made to utilize pressure relieving footwear for Resident #6. The DON stated she did not know the last time attempts had been made to address pressure relieving footwear for Resident #6. In a follow-up interview on 02/19/14 at 11:40 AM the DON provided documentation showing a pressure relieving boot had been ordered for Resident #6 on 12/06/12 and discontinued 01/17/13. The DON stated the pressure relieving boot had been discontinued on 01/17/13 due to refusal to wear by Resident #6. The DON stated she was not aware of any assessments or trials of pressure relieving footwear for Resident #6 since 01/17/13. On 02/18/14 at 4:30 PM Nurse #2 reported he routinely worked with Resident #6 from 3:00 PM-11:00 PM. Nurse #2 stated the hard athletic style shoes were usually on Resident #6 at the start of his shift. Nurse #2 stated it was the preference of Resident #6 to wear the hard, athletic style shoes. Nurse #2 stated he had never tried any other footwear on Resident #6 and didn't know if anyone else had tried alternatives to the hard, athletic style shoes.	F 314		
F 333 SS=D	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview the facility failed to administer the accurate dose of Coumadin to 1 of 3 sampled	F 333		

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residents on Coumadin.
(Resident #6)

The findings included:

Resident #6 was admitted to the facility 11/14/12 with diagnoses which included atrial fibrillation.

The current care plan for Resident #6 dated 01/13/14 included the problem area, At risk for complications related to anticoagulant use due to atrial fibrillation. Approaches to this problem area included to obtain and monitor lab/diagnostic work as ordered. Report results to physician and follow up as indicated.

a. Review of the Prothrombin Time/International Normalized Ratio (PT/INR) Flow Sheet for Resident #6, physician orders and Medication Administration Record (MAR) noted the following. On 11/01/13 Resident #6 was receiving 10 milligrams of Coumadin a day. On 11/01/13 the PT/INR results were noted as 23.4/2.0 (with 2-3 the normal limit of INR). PT/INR is a test used to monitor Coumadin and determine dosing changes. The physician/family nurse practitioner was notified of the lab results and orders were to keep the dose at 10 milligrams of Coumadin a day. The electronic medical record noted that at 3:53 PM Nurse #3 entered an order to keep Coumadin at 10 milligrams with a 4:00 PM administration time. At 4:17 PM Nurse #3 discontinued the order for 10 milligrams of Coumadin at 4:00 PM and changed the administration time to 7:00 PM. Review of the November 2013 MAR for Resident #6 noted the 4:00 PM dose was signed as given as well as the 7:00 PM dose on 11/01/13. The doses were signed as administered by the same staff

F333

All medication Aides and licensed staff will be re-educated on the Clinical Guidelines of Anti-Coagulant administration of medications. They will also be re-educated on Coumadin order entry with standard administration standard Coumadin administration and entry of dosage on Medication Transcriptions guidelines. All licensed nurses will be re-educated on the proper transcribing of Physician orders. The Dir. of Nursing/designee will daily compare lab results with MAR's ,all new Physician Orders and the 24 hour reports. Patient #6 Had no negative outcome from Coumadin error. Dir. of Nursing or designee will monitor all residents on Coumadin per lab (INR) schedules. The monitoring will be ongoing. Patient # 6's orders were audited and reviewed. This will be monitored through the QAPI process and reviewed monthly with the QA meeting.

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member for a total of 20 milligrams of Coumadin, instead of the 10 milligrams as ordered.

On 02/18/14 at 3:25 PM the Director of Nursing (DON) verified the 20 milligrams was signed as given to Resident #6 on 11/01/13. The DON noted the electronic MAR does not display the entire MAR when staff are administering medications. The DON stated only medications due at the specific time are displayed on the MAR for each individual resident. The DON stated when Nurse #3 entered the first dose of Coumadin at 3:53 PM it would have displayed at 4:00 PM for administration. The DON stated when the dose was changed at 4:17 PM it would have displayed at 7:00 PM. As a result, the DON stated at 4:00 PM and 7:00 PM the electronic MAR would have separately displayed the order for 10 milligrams of Coumadin. The DON supposed the medication technician (that signed the electronic MAR of Resident #6 on 11/01/13) did not recall administering the 10 milligrams of Coumadin at 4:00 PM when the dose was signed as given at 7:00 PM. The DON stated the medication technician that administered this Coumadin no longer worked at the facility and was not available to be interviewed.

On 02/18/14 at 3:55 PM Nurse #3 stated she could not recall the circumstances surrounding the 11/01/13 Coumadin order for Resident #6 but that she might have changed the administration order from 3:53 PM to 7:00 PM to ensure Resident #6 received the medication on 11/01/13. Nurse #3 stated if a medication is entered after the administration due time it will not show up until the following day and since 3:53 PM was so close to 4:00 PM she most likely changed it to 7:00 PM to ensure Resident #6 received the

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F 333	Continued From page 22 medication the evening of 11/01/13. b. Review of the electronic Medication Administration Record (MAR) revealed on 12/13/13 Resident #6 was receiving 7 milligrams of Coumadin a day. On 12/13/13 the PT/INR results were noted as 15.9/1.4. The physician/nurse practitioner was notified of the lab results by Nurse #4 on 12/14/13 and orders written on the lab result noted to increase the Coumadin from 7 milligrams to 8 milligrams. Nurse #4 entered the new Coumadin dose as 7 milligrams on the PT/INR flow sheet as well as the December MAR for Resident #6. Review of the December electronic MAR for Resident #6 noted he received 7 milligrams of Coumadin from 12/14/13-12/16/13 until the next PT/INR on 12/17/13. The PT/INR results on 12/17/13 were 32.8 and 2.9. On 02/18/14 at 4:15 PM Nurse #4 stated she made a mistake when she wrote the dose of 7 milligrams versus 8 milligrams on the PT/INR flow sheet and electronic MAR for Resident #6 on 12/14/13.	F 333		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections	F 441	F441 Re-educate all licensed staff on Infection Control Policies related to wound care and cross contamination will be preformed by all licensed staff by Dir. of Nursing/designee. The Dir. of nursing or designee will audit two dressing changes weekly for one month and one per month thereafter. An ongoing QA will be performed and reported at the monthly QA meeting. 3-19-14	

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in the facility;
(2) Decides what procedures, such as isolation, should be applied to an individual resident; and
(3) Maintains a record of incidents and corrective actions related to infections.

(b) Preventing Spread of Infection
(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.
(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.
(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.

(c) Linens
Personnel must handle, store, process and transport linens so as to prevent the spread of infection.

This REQUIREMENT is not met as evidenced by:
Based on observations, record review and staff interviews the facility failed to wash hands and change gloves to prevent cross contamination of multiple wounds for 1 of 3 residents observed for wound care (Resident #2) and to prevent contamination of environmental surfaces.

The findings included:

Review of an undated policy titled "Clean

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Dressing Change Audit" included the following guidelines:
- gather equipment: dressings, prescribed ointments/medications, clean gloves (3 pairs), cleaning solution, plastic bag for soiled materials, paper towel or towel for clean field
-create clean field with paper towels/towel
-open dressings
-cleanse wound with prescribed solution, working from the inside out, using a separate piece of gauze or cotton swab for cleansing each area; then, discard into plastic bag
-wash hands and put on clean pair of gloves
-apply prescribed medication using a clean tongue blade or cotton swab; use a separate tongue blade or cotton swab for each area; discard used tongue blade or cotton swab into plastic bag
-remove gloves and discard into plastic bag
-wash hands
-dispose of plastic bag in the utility room - wash hands.

On 02/17/14 at 2:45 PM Nurse #1 was observed providing wound care to 6 Stage 2 Moisture Associated Skin Deterioration (MASD) areas on the right upper posterior thigh and left buttock of Resident #2 , which were open and bleeding. When Nurse #1 started to provide the wound care, the resident was observed to be incontinent of stool that had soiled the sheet underneath her. There was blood and stool visible on the side of the sheet which was against the mattress when the nurse aides removed the sheet. Nurse Aides provided incontinence care and removed the sheet prior to Nurse #1 providing treatment to Resident #2's wounds. A large brown discolored area was visible on the mattress in the center of the bed.

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Nurse #1 washed her hands in the resident's bathroom then donned a clean pair of gloves. She then placed a bottle of wound cleanser, a tube of MediHoney and multiple packs of 4 X 4 gauze directly onto the mattress near the foot of the bed near an open plastic bag. Starting with the left buttock, she sprayed wound cleanser directly onto an open, bleeding wound and wiped across the wound with the 4 X 4 gauze. She folded the same gauze pad in half, then sprayed another open, bleeding wound with wound cleanser and wiped across that wound with the folded gauze pad. She discarded that gauze pad in the plastic bag at the foot of the bed. She then proceeded to clean all the open bleeding wounds in the same manner, using one gauze pad to clean 2 wounds each time. When she had cleaned all the wounds, she picked up the tube of MediHoney and squirted MediHoney from the tube onto her gloved hand. She then applied the ointment directly onto the open wounds which were seeping blood. She squirted additional ointment out of the tube several times during the treatment and continued applying the ointment to the wounds with her gloved hand until the ointment had been applied to all the open wounds. She then removed her gloves, placed them in the bag with the soiled gauze and tied the top of the bag. Without washing her hands or putting on clean gloves, she picked up the bottle of wound cleanser, the tube of MediHoney and the plastic bag and opened the door to the resident's room. She then walked down the hall to the shower room, opened the door to the shower room and discarded the plastic bag. She then went to the treatment cart and placed the bottle of wound cleanser and tube of MediHoney on top of the treatment cart, labeled them with the

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resident's name then placed them in the treatment cart without disinfecting the containers or placing them in a plastic storage bag. She then went to the nourishment room, entered the code on the keypad to unlock the door and went to the sink in the nourishment room to wash her hands.

In an interview with Nurse #1 on 02/17/14 at 2:55 PM, the nurse was asked about not changing her gloves between cleaning the open, bleeding areas on Resident #2's buttock and thigh prior to applying the ointment and she stated she should have changed her gloves. When asked about placing the wound cleanser and MediHoney in the treatment cart with clean supplies, she stated there were zip-top bags available to put the items in and she returned to the treatment cart and placed both items in a plastic zip-top bag and labeled it with the resident's name.

In an interview with Nurse #1 on 02/18/14 at 2:15 PM, the nurse was asked about using the same gauze pad to clean different open wounds, she stated she should have used a clean gauze pad to clean each area. Nurse #1 was asked about not washing her hands or putting on clean gloves before leaving the resident's room and carrying the contaminated wound cleanser and MediHoney containers in her ungloved hands then touching the door to the resident's room, the shower room, the treatment cart and the nourishment room. Nurse #1 stated she should have washed her hands and put on clean gloves to carry the wound cleanser and MediHoney back to the treatment cart.

An interview with the Director of Nursing (DON) on 02/19/14 at 10:10 AM about her expectation for the nurses to follow the facility's procedure for

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wound care revealed she expected the nurses to follow the guidelines in the policy. When the DON was asked how multiple wounds on a resident should be cleansed, she stated a clean gauze should be used for each site. When the DON was asked if the container of wound cleanser and the MediHoney would be considered contaminated after being placed on the resident's bed and handled by the nurse while she was cleaning and applying ointment to open, bleeding wounds, she stated they would be contaminated. She stated the containers should have been disinfected or discarded before being taken out of the resident's room. When the DON was asked if carrying the containers in ungloved hands would have contaminated the nurse's hands, she stated it would have. The DON stated every environmental surface the nurse touched would possibly be contaminated. When the DON was asked about her expectation for putting the wound cleanser and MediHoney on the treatment cart, she stated they should have been placed in a plastic bag labeled with the resident's name.

F 514 SS=D 483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE — F 514

The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.

The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State;

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This REQUIREMENT is not met as evidenced by:
Based on medical record review and staff interviews the facility failed to transcribe Coumadin orders for 2 of 3 sampled residents consistent with the facility policy and to accurately reflect the actual physician order. (Residents #6 and #8)

The findings included:

1. Resident #6 was admitted to the facility 11/14/12 with diagnoses which included atrial fibrillation.

The current care plan for Resident #6 dated 01/13/14 included the problem area, At risk for complications related to anticoagulant use due to atrial fibrillation. Approaches to this problem area included to obtain and monitor lab/diagnostic work as ordered. Report results to physician and follow up as indicated.

a. Review of November 2013 physician orders in the medical record of Resident #6 noted an order on 11/29/13 for 8 milligrams of Coumadin a day. This order was written and displayed in the November and December 2013 electronic Medication Administration Record (MAR) for Resident #6 as, Coumadin Tablet 4 milligrams (mg). Give 8 mg by mouth at bedtime.

b. Review of December 2013 physician orders in the medical record of Resident #6 noted an order on 12/24/13 for 6.5 mg of Coumadin. This order was written and displayed in the December

F514
All licensed nurses will be re-educated on the Clinical Guidelines of Anticoagulant administration of medications. They will also be re-educated on Medication order entry with standard Coumadin administration time and entry of the dosage. Nurses will be re-educated on the proper transcribing of Physician orders. The Dir. of Nursing/designee will daily compare lab results with MAR's ,all new Physician Orders and the 24 hour reports. Patient #6 Had no negative outcome from Coumadin error. Patient # 6's orders were audited and reviewed for errors . This will be monitored through the QAPI process and reviewed monthly with the QA meeting. Resident #8 was assessed and there were no negative outcomes. The Dir. of Nursing/designee will monitor all residents who are on Coumadin per lab (INR) schedules.

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electronic MAR for Resident #6 as, Coumadin 2.5 mg. Give 6.5 mg at bedtime. Coumadin 4.5 mg. Give 6.5 mg at bedtime.

c. Review of February 2014 physician orders in the medical record of Resident #6 noted an order on 02/01/14 for 4.5 mg of Coumadin every Sunday, Tuesday, Thursday and Saturday. This order was written and displayed in the February electronic MAR for Resident #6 as, Coumadin 2 mg. Give 4.5 mg by mouth at bedtime every Sunday, Tuesday, Thursday, Saturday. Coumadin 2.5 mg. Give 4.5 mg by mouth at bedtime every Sunday, Tuesday, Thursday, Saturday.

On 02/18/14 at 3:55 PM the Director of Nursing (DON) reviewed the November, December and February MARs for Resident #6; specifically, the Coumadin orders. The DON stated she was not aware nurses were writing orders in split doses and noted the way the 11/29/13, 12/24/13 and 02/01/14 orders for Resident #6 read on the MAR was confusing. The DON stated Coumadin orders should be put into the electronic MAR with the actual dose. The DON stated the electronic MAR defaulted to set doses of Coumadin (1 mg, 2 mg, 3 mg, 4 mg, 5 mg, 6 mg,....) and newer nursing staff may not know how to bypass the default amounts of Coumadin to enter the actual dose ordered by the physician.

2. Review of the facility Entering Coumadin/INR Orders protocol noted the following:
Step 1: Anticogulant order
-Enter the new Coumadin order under order type: anticoagulant
-For MAR end date, choose fixed and enter the date one day prior to the next scheduled INR

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-Choose the new Coumadin dose as usual
-Under directions, enter the current Coumadin dose and indicate when the next INR is due
-Complete order as usual

Resident #8 was admitted to the facility 12/25/12 with diagnoses which included cardiac dysrthymia.

The current care plan for Resident #8 included a problem area, At risk for complications related to anticoagulant or antiplatelet medication due to Coumadin use. Approaches to this problem area included, Obtain and monitor lab/diagnostic work as ordered.

Review of the Prothrombin Time/International Normalized Ratio (PT/INR) Flow Sheet for Resident #8, physician orders and Medication Administration Record (MAR) noted the following. On 02/14/14 Resident #8 was receiving 9.5 milligrams (mg) of Coumadin a day. Physician orders on 02/14/14 included to hold the Coumadin and to recheck the PT/INR on 02/15/14. Documentation on the PT/INR flow sheet on 02/15/14 noted that two attempts were made to draw blood to check the PT/INR but were unsuccessful. Physician orders on 02/16/14 included to initiate 9 mg of Coumadin and recheck the PT/INR on 02/18/14. Review of lab results for Resident #8 noted the PT/INR results from 02/18/14 were 14.3/1.3 (with 2-3 the normal limit of INR). PT/INR is a test used to monitor Coumadin and determine dosing changes. Physician orders on 02/18/14 included to increase the Coumadin to 9.5 milligrams a day and to recheck the PT/INR on 02/24/14.

Review of the February 2014 electronic MAR for

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Resident #8 noted 9 mg of Coumadin was signed as given on 02/16/14 and 02/17/14. On 02/18/14 18.5 mg of Coumadin was signed as given by Nurse #2 under two separate orders on the electronic MAR. The Coumadin order on the February MAR for Resident #8 was in two separate entries that read as follows:
Order date-02/16/14 2:41 PM Coumadin tablet. Give 9 mg by mouth one time a day until 02/18/14 23.59 (4:00 PM)
Order date-02/18/14 3:09 PM Coumadin tablet. Give 9.5 mg by mouth in the afternoon (4:00 PM)

On 02/19/14 at 6:15 PM Nurse #5 (that wrote the 02/16/14 Coumadin order for Resident #8) stated she had attempted to contact the Family Nurse Practitioner (FNP) on 02/15/14 about the failed attempt of the PT/INR for Resident #8 on 02/15/14. Nurse #5 stated on 02/16/14 she spoke to the FNP and received the orders to give 9 mg of Coumadin and recheck the PT/INR on 02/18/14. Nurse #5 stated her understanding was to write the order for Coumadin up through the day the next PT/INR is due; which was why it was included through 02/18/14.

On 02/19/14 at 5:15 PM the Director of Nursing (DON) stated that the Entering Coumadin/INR Orders protocol (referenced above) guides the nurse to enter the last dose of Coumadin the day prior to the next PT/INR due date. The DON explained the electronic MAR does not display the entire MAR when staff are administering medications. The DON stated only the medications due at the specific time are displayed on the MAR for each individual resident. Because of this, both the 9 mg and 9.5 mg dose of Coumadin would have displayed for Resident #8 at 4:00 PM on 02/18/14. The DON stated that

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because Nurse #5 included the 9 mg of Coumadin through 02/18/14 (the day the next PT/INR was due) versus 02/17/14 (per protocol, stopping the dose the day before the next PT/INR was due) the Coumadin displayed twice on the electronic MAR on 02/18/14 for administration

On 02/19/14 at 4:05 PM Nurse #2 (that signed the administration of both the 9 and 9.5 mg of Coumadin for Resident #8 on 02/18/14) stated he only gave 9.5 mg, not 18.5 mg as documented. Nurse #2 stated he mistakenly signed off that the 9 mg had been given but knew the actual order was for 9.5 mg.