STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	325045	A. Building B. Wing	11/09/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Princeton Health & Rehabilitation	500 Louisiana Boulevard NE Albuquerque, NM 87108

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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40794 R #1 was admitted to the facility on [DATE] with known history of decannulating (removing tracheostomy tube: curve tube inserted in the neck and windpipe) himself. On [DATE] and [DATE], R #1 is observed pulling on his trach. On [DATE], R #1 decannulated himself twice (in the morning and late afternoon) and was provided one on one (one resident to one staff) observation overnight which was then discontinued in the morning. On [DATE], R #1 decannulated himself and the trach was reinserted. No new interventions were implemented. On the morning of [DATE], R #1 decannulated himself and the trach was reinserted. The Provider was not notified and no interventions to prevent decannulation were implemented. Approximately 1. 5 hours after the first decannulation on [DATE], R #1 was found unresponsive with his trach remove and life saving measures were unsuccessful. This resulted in an Immediate Jeopardy (IJ) at a scope and severity of J being called on [DATE] at 5:15 pm with the Administrator being advised. The facility took corrective action by providing an acceptable Plan of Removal (POR) on [DATE] at 11:59 am. Implementation of the POR was verified and approved onsite at 5:30 pm on [DATE] and the Scope and Severity was reduced from the level J to a level G. The Plan of Removal interventions included: IDENTIFICATION OF RESIDENTS AT RISK FOR SAME FAILED PRACTICE We immediately identified all active patients at risk for the alleged failed practice. Going forward, all tracheostomy referrals will be reviewed by the Respiratory Therapy (RT) Director with bedside review completed prior to admission. Any nursing concerns identified for potential high-risk patients will be reviewed by DON (Director of Nursing) and/or designee prior to admission. The DON and/or designee will assess new admissions in person within one business day of admission to identify any potential high risk needs and implement care plans. ASSESSMENTS REQUIRED TO DETERMINE WHAT IMMEDIATE ACTIONS ARE NECESSARY TO LIFT THE IMMEDIATE JEOPARDY Respiratory assessments were immediately performed by nursing leadership for all currently identified high risk patients in order to determine what immediate actions are necessary in order to ensure that there is no immediate jeopardy to their health and safety. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	TRAINING OF STAFF TO ENSURE THEY HAVE KNOWLEDGE OF ACTIONS REQUIRED UNTIL THE PLAN OF CORRECTION IS IMPLEMENTED Re-education began immediately on [DATE] for all licensed staff regarding facility policy related to change in condition, and orders and frequent monitoring of high-risk patients. Re-education for all staff regarding facility policy related to change in condition occurred on [DATE] and [DATE]. The respiratory therapy department and the admissions department received an in-service for identifying potential high risk patients on [DATE]. MONITORING BY SUPERVISORS TO ENSURE THAT STAFF ARE FOLLOWING THE PLAN OF REMOVAL Monitoring began immediately on [DATE]. DON's and/or ADON's (Assistant Director of Nursing) will run and review the Facility Activity Report daily to review abnormal progress notes and to review any abnormal vital signs. An IDT (Interdisciplinary Team which involves staff members from different departments discussing the care needs of residents) note will be completed within one business day of a change in condition to assure all updates and proper notifications were completed. The Regional Nurse Consultant (RNC) will perform daily audits of trach patients and will review daily the Change in Condition Report to assure proper follow up and care compliance. Nursing in-service on changes in condition requirements were completed on [DATE] and [DATE]. Within ,d+[DATE] hours of expected completion of this monitoring, the DON's and/or ADON's will assess the work to identify any missing items. The RNC will complete a weekly IDT audit to ensure that IDT items are completed in a timely manner. DOCUMENTATION OF FACILITY'S ACTIONS UNTIL THE PLAN OF CORRECTION IS IMPLEMENTED All actions herein will immediately be documented via in-service records and logs, where necessary. The IDT will audit the in-service records and logs daily in IDT. Based on record review and interview, the facility failed to ensure 1 (R #1) of 3 (R # 1, 2, and 3) residents reviewed received the appropriate care when R #1 was admitted with a known history of decannulating himself and decannulated himself 5 times in 4 days, and the facility failed to notify the Physician of frequent behaviors (decannulation), provide the appropriate supervision and implement interventions to prevent continued decannulation. This deficient practice likely resulted in R #1's death. The findings are: A. Record review of R #1's face sheet revealed he was admitted to the facility on [DATE]. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	B. Record review of R #1's face sheet revealed he was admitted to the facility with the following diagnoses: traumatic brain injury (resulting from a violent blow or jolt to the head), epilepsy with seizures or convulsions (sudden, uncontrolled electrical disturbance in the brain which can cause changes in behavior, movements, feelings, and consciousness), insomnia (trouble falling or staying asleep), encephalopathy (medical term used to describe a disease that affects brain structure or function and causes altered mental state and confusion), hypertension (blood pressure that is higher than normal), acute respiratory failure (not enough oxygen being exchanged in the lungs), muscle wasting and atrophy (loss of muscle mass due to not getting regular exercise), bradycardia (slow heart rate), dysphagia (difficulty swallowing), type 2 diabetes (disease that occurs when blood sugar is too high), moderate protein-calorie malnutrition (not consuming enough nutrients leading to bodily breakdown and functions), anxiety, tracheostomy status and gastrostomy status (an opening that surgeons make into the stomach in which a tube is placed to provide nutritional support also known as tube feeding via a g-tube). C. Record review R #1 [hospital name] hospital records dated [DATE] revealed on [DATE] the resident had decannulated himself in the hospital. D. Record review of R #1's Physician orders dated [DATE] revealed that hydroxyzine (anxiety medication) HCl 25 mg (milligrams) was prescribed every 6 hours PRN (as needed). E. Record review of R #1's progress notes dated [DATE] at 3:15 am revealed (R #1) was admitted with mitten restraints due to decannulizing (decannulating) himself in the hospital. Mittens were removed. F. Record review of R #1's progress notes posted by Respiratory Therapist [RT] #1 dated [DATE] at 12:10 pm revealed Resident trach site cleaned, and new drain sponge and paper towel drape placed, he is pulling on the trach mask the drape and touching his face, I'm concerned that he may inadvertently (without intention, accidentally) pull his trach out. G. Record review of R #1's progress notes posted by Respiratory Director [RD] /RT #2 dated [DATE] at 8:30 am revealed Resident pulling at his trach collar. H. Record review of R #1's progress notes posted by RD/RT #2 dated [DATE] at 10:16 am revealed RT entered room and found the trach collar on the floor. Sterile technique performed and the #6 Bivona (size and brand name) trach was put back in with the assistance of the nurse and CNA (Certified Nursing Assistant). I. Record review of R #1's progress notes posted by Registered Nurse [RN] #1 dated [DATE] at 16:11 (4:11 pm) revealed At 1530 (3:30 pm) the CNA notified this nurse and the eve (evening) shift nurse that the patient pulled his trach out, RT was called STAT (immediately), crash cart was brought to room, could not get an oxygen saturation. RT stabilized trach and oxygen. Saturation was at 98%. Patient begin to move hands up to trach. J. Record review of R #1's progress notes dated [DATE] at 22:23 (10:23 pm) and posted by RT #3 revealed Resident was awake at room entry and was restless (unable to rest or relax as a result of anxiety). (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	K. Record review of R #1's Medication Administration History revealed hydroxyzine HCl was administered once (1 time) on [DATE] at 8:09 am. L. On [DATE] at 11:34 am, during an interview, RD/RT #2 confirmed R #1 had decannulated himself on [DATE]. RT #2 stated that R #1 was very agitated, so she needed help to put the trach back in. She stated she had to use the crash cart (a wheeled container carrying medicine and equipment for use in emergency resuscitations, which is the action taken when reviving someone from unconsciousness or apparent death) to bring him back to life. RD/RT #2 confirmed that night [[DATE]] he had been initiated with a one on one care nurse aide [supervision] and that this was initiated by nursing staff. M. Record review of R #1's progress notes dated [DATE] at 00:50 (12:50 am) and posted by RT #3 revealed Resident was awake and restless at room entry. N. Record review of R #1's progress notes posted by RT #3 dated [DATE] at 22:45 (10:45 pm) revealed Summoned (urgently called) to the resident's room. The resident had decannulated himself. Stoma (opening in the windpipe) and trach were sterilized and the trach was reinserted with small resistance (refusal to accept or comply with something). O. Record review of R #1's Medication Administration History revealed hydroxyzine HCl was not administered on [DATE]. P. Record review of R #1's progress notes posted by the Assistant Director of Nursing [ADON] dated [DATE] at 10:40 am revealed a late entry regarding the IDT (interdisciplinary team) meeting held on [DATE] at 9:30 am IDT discussed the intervention for the need to assess Mr. [last name of R #1] for air hunger (sensation of not being able to breathe sufficient air) and review of medications for agitation (state of being troubled or nervous). Q. Record review of R #1's progress notes posted by RN #2 dated [DATE] at 8:00 am revealed Resident noted with trach out of stoma. Resident labored breathing (difficulty breathing). RT notified. Repositioned resident with RT for trach reinsertion (to put back in place), trach reinserted. R. Record review of R #1's progress note dated [DATE] at 8:13 am stated the following: found him decannulated and he was struggling to breathe, the nurse said it just happened, soaked the trach in Hydrogen peroxide solution and used a brush to clean it thoroughly, used sterile water-based lube to reinsert, some bleeding noted. Resident verbalized that, it wasn't so hard to breathe in response to me asking him, if it was (hard to breathe). S. Record review of R #1's progress notes posted by RN #2 dated [DATE] at 9:45 am revealed Called to resident room by CNA about resident not breathing. Upon entering room, resident not breathing. RT already in room re-inserting the trach that was out of the stoma. No heart sounds were heard to auscultation (act of listening to the internal sounds of the body). Trach reinserted. CPR (Cardiopulmonary Resuscitation) now started at 0950 (9:50 am). 911 called at 0955 (9:55 am) will several rings and no answer. Called 911 again at 0957 (9:57 am). EMS (Emergency Medical Services) arrived at 1005 (10:05 am) to take over resident CPR. EMS continues CPR until 1030 (10:30 am). 1030 EMS stopped CPR and resident was deceased (no longer alive). 1035 (10:35 am) resident assessed for death. No lung sounds heard to auscultation. No heart sounds heard to auscultation. Eyes are dilated (to make wide or larger) non-reactive to light. Resident pronounced deceased at 1035 on [DATE]. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	T. On [DATE] at 9:23 am, during an interview, the Administrator (ADM) stated R #1 was admitted on [DATE] as a trach patient being followed by the respiratory department. The ADM confirmed that on [DATE] at 8:00 am R #1 was found decannulated in his room and they reinserted the cannula and resident was comfortable and received a nebulizer treatment with normal vital signs. The ADM reported that at 9:45 am, the Respiratory Therapist returned, and R #1 was decannulated and not breathing. He stated code blue was called and 911 was called. Compressions were done and EMS arrived at 10:05 am and called the code and R #1 expired at 10:30 am. U. On [DATE] at 11:09 am, during an interview, RT #1 stated he had worked with R #1 the day ([DATE]) he passed away. RT #1 confirmed that R #1 decannulated himself at 8:00 am and with the assistance of a nurse they put a new trach in and then he (RT #1) went to chart. RT #1 stated the R #1 told him It is ok while he was decannulated and that he was wearing mittens since he was admitted . RT #1 reported that mittens are used to prevent the resident from decannulating himself. V. On [DATE] at 11:56 am, during an interview, Director of Nursing [DON] #1 confirmed she never witnessed R #1 pull his trach out. DON #1 confirmed that at times R #1 was agitated but given hydroxyzine (a medication used to treat anxiety, a feeling of uneasiness, worry or fear) to assist with him not to pull it [trach] out. DON #1 stated on the day he passed away ([DATE]), hydroxyzine was not given. She confirmed the patient appeared stable and not agitated at that time as reason decision was made not to give R #1 hydroxyzine. DON #1 confirmed he [R #1] was not put back on one on one care due to not needing it after assessment of R #1 [on [DATE] when one to one staffing was discontinued] and that R #1 would sometimes take his mittens off. DON #1 reported that removing mittens would not be considered a behavior, but it could have been the result of irritation. DON #1 stated that she is not sure if she would have recommended one on one care the morning [[DATE]] he passed due to the resident being stable, but did confirm that nurses can initiate the one on one care when necessary. W. On [DATE] at 12:09 pm, during an interview, RN #1 stated she was not in the facility when R #1 was admitted . RN #1 confirmed that R #1 would take his mittens off at times. X. On [DATE] at 12:44 pm, during an interview, the ADM stated he had no reports by staff of behavior issues with R #1 and he is unsure of why he was pulling his trach out. The ADM reported that during staff rounding they would try to make sure he wore his mittens to not pull his trach. The ADM confirmed the judgement call made on [DATE] was R #1 was doing well and not in distress at the time to need one-on-one care the morning he expired. The ADM confirmed that at times he is a part of that conversation when one on one care is needed, but the clinical leaders and unit managers make the main call (decision). The ADM reported that he is not sure if he would have recommended one on one care at the time. The ADM confirmed they do not have a policy on one on one care and that R #1 just didn't want the trach in. Y. On [DATE] at 9:14 am, during an interview, RN #2 confirmed he had worked from the afternoon 11:00 pm on [DATE] through [DATE] the morning the R #1 expired. RN #2 stated R #1 was wearing his mittens. RN #2 confirmed he was told about the resident decannulating himself when he came on his shift on [DATE] and that R #1 was not on one on one care at the time he expired. RN #2 reported that on his shift R #1 was fine, no behaviors noted and no issues throughout the night, and one on one care was not needed due to resident being stable. RN #2 confirmed that after R #1 decannulated himself [on [DATE] at approximately 8:00 am (first time)] he did not call the provider for further direction. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Z. On [DATE] at 8:59 am, during an interview, CNA #1 reported that he had only worked with R #1 on the morning ([DATE]) he passed away and he confirmed he did not observe any behaviors for R #1. CNA #1 confirmed that R #1 had mittens on his hand and would try to pull his trach out. CNA #1 stated R #1 does not talk very clearly, but he asked if he was doing ok throughout the shift. AA. On [DATE] at 11:01 am, during an interview, the Assistant Director of Nursing stated she reviewed the resident chart and confirmed she was aware of R #1 decannulating himself a few days after he was admitted to the facility. The ADON confirmed that they initiated the one on one care overnight [[DATE]] and the next day the staff were considering whether air hunger (strong urge to breathe or a feeling of severe breathlessness) was the reason R #1 was pulling out his trach. ADON confirmed that the one to one staff initiated on [DATE] was discontinued by the Unit Manager on [DATE] because the resident was stable. The ADON reported that the morning [[DATE]] R #1 passed, the Nurse on at the time did not call the physician. BB. On [DATE] at 11:27 am, during an interview, Unit Manager (UM) #2 stated she does not recall making the decision to take R #1 off the one on one care. UM #2 stated that R #1 should had not been admitted to the facility in the first place. UM #2 stated she spoke with all of the ADON's and let them know about him pulling his trach out. She confirmed she personally felt R #1 needed to be on one on one care for a longer period of time and that she told upper management that they can't provide the care he needs. She stated she did not know why they would accept him with the condition he was in. UM #2 stated she spoke with staffing, and they assigned one CNA for the evening [[DATE]] into the morning. UM #2 stated she never observed any behaviors that would indicate the resident had behaviors at the facility to pull out his trach. UM #2 reported that after R #1 pulled his trach out again, the Nurse should have initiate one on one care and contacted the provider to get him out of the facility due to him not being safe. UM #2 stated the agitation R #1 had, was not wanting it [trach] in. UM #2 stated he should have not been there in the first place and should have been sent to the hospital for further evaluation and a better placement elsewhere. UM #2 confirmed that she stepped down [from her position] because of the DON and ADM admitting [other] residents in this condition. CC. On [DATE] at 10:17 am, during an interview, DON #2 confirmed she requested a policy on one on one care that the facility had in place and was told they didn't have one. She stated she wanted to know why one to one would be initiated and then discontinued. DON #2 confirmed that she was unaware until she reviewed the notes that R #1 had a one on one initiated the first time, he decannulated himself and that she was unaware of his behaviors that he pulled his trach out. DON #2 stated she was told after his first time pulling his trach out that he was stable and doing good and she thought the physician was notified and it was not until after she did more investigating about the situation did she realize the provider was not notified. DON #2 confirmed RN #1 was supposed to call the physician for further guidance [on the morning of [DATE]]. DON #2 stated nobody asked her about the situation or told her about the decisions being made with the resident care. DON #2 stated had she been notified about the second decannulation she would have said to call the physician for further guidance and to recommend one on one care immediately. DON #2 confirmed she asked the nurse the morning of the death [[DATE]] how he did not see that the resident pulling his trach out was not a change of condition and to notify the provider. She confirmed that she educated the nurse that he should have contacted the physician and initiated one on one care until he got a hold of the physician for further guidance. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	DD. On [DATE] at 1:44 pm, during an interview, DON #1 confirmed they stopped the one on one care for R #1 on [DATE] in the morning due to stopped behaviors and stabilized after receiving medications. She stated they have not had this issue in the facility other than with R #1. DON #1 stated they continued to monitor him and he received treatments from the respiratory department. DON #1 stated that there was no reason R #1 should have continued to decannulated himself. EE. On [DATE] at 10:12 am, during an interview, DON #1 stated the nursing judgment is used for one on one care. She confirmed they do not have a policy on one on one care. DON #1 confirmed there could have been an order to put in for R #1 to be put on one on one care to indicate that patient safety is of concern. DON #1 confirmed that the facility could have notified the provider to get additional guidance to put R #1 on one on one care for a longer period of time. DON #1 confirmed that if a resident pulls out their trach death is the consequence if nobody intervenes right away within 10 minutes. FF. On [DATE] at 4:18 pm during an interview, the ADON reported that they did not use mittens for R #1 to prevent decannulation as they are considered a restraint. She reported that due to R #1 pulling out his trach and to prevent serious harm, the facility should have sent him back to the hospital for a higher level of care to include using a telesitter (someone that can continuously monitor for risky behavior). She reported staffing wise, we don't have that ability. The ADON reported that they did not think to assess R #1 for self-harm or suicidal behaviors. She reported that hospital records from [name of the transferring hospital] only listed one decannulation and they (the staff) do not consider that a history as it could have been an accidental decannulation. The ADON reported that they discussed R #1's medication for the agitation behaviors during the IDT (interdisciplinary meeting, which involves staff members from different departments discussing the care needs of residents) held on [DATE] and a staff member was to follow up with the physician to see what (medication) they could give him (R #1), but she was not sure if that happened or not. GG. On [DATE] at 2:37 pm, during an interview, DON #1 reported that they did not follow up with the physician regarding medication to address R #1's agitation, because making outreach to the physician was not discussed in the IDT meeting that occurred on [DATE] at 9:30 am. HH. On [DATE] at 11:10 am, during an interview, RN #4 reported that she remembers that R #1 was admitted to the facility with mitten restraints due to decannulizing himself in the hospital, but she does not remember why the staff decided to remove R #1's mittens. She reported given the risk of residents pulling out trachs, the appropriate level of care that should be given to prevent serious harm would be rounding at least every two hours by the respiratory department and nursing, because there is a lot of care needed in terms of checking on the residents and anticipating their needs. II. On [DATE] at 4:51 pm, during an interview, RT #3 reported that he advised R #1 of the consequences of pulling at his trach. RT #3 reported that he told R #1 this trach is there for a reason, it's there to help you breathe and without it you will not be able to breathe and you need to not pull at it. RT #3 reported that R #1 was definitely restless with his hands, but he is unsure if R #1 was pulling on his trach intentionally as they (the staff) were not sure if he (R #1) even understood what they (the staff) were telling him (R #1). RT #3 reported that when residents with trachs are restless, he notifies the nurse to see if there is anything they can do to address the issue such as administer medication. RT #3 confirmed that he told the nurses after every encounter with R #1 that he [R #1] was restless. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	JJ. On [DATE] at 1:41 pm, during an interview, the RD/RT #2 reported that she told R #1 to stop pulling out his trach, because it's dangerous and that the hole (in his windpipe) could close up and he could pass away, but it was not charted (documented in R #1's electronic medical record). She reported that she felt R #1 did not understand what she was telling him due to his brain injury. RD/RT #2 reported that R #1 would become very agitated (appearing troubled or nervous) and she told the nurses so they could give him medication. She reported that the staff should have ensured that R #1 was checked on more frequently by the nurses. RD/RT #2 reported that a good staff to resident ratio is important and she feels they were short-staffed nursing wise at the time R #1 was at the facility. She reported that educating the residents and ongoing communication between the nurses and respiratory therapy should be occurring to ensure that issues are being addressed when a resident is decannulating themselves such as getting medications ordered for agitation. KK. On [DATE] at 2:37 pm, during an interview, DON #1 reported that R #1 was in the appropriate level of care and the team never thought they needed to send him (R #1) out (to another facility or hospital) or call the physician, because he was stabilized each time he decannulated himself. She reported we did not look at it on a global scale (entire health care situation), we looked at it on a per incident (per decannulation) basis. DON #1 reported R #1 did have a history of decannulation while at [name of transferring hospital] and he came with mittens (to prevent decannulation) from there, but we (the staff) did not continue that [the mittens] as there was no physicians order for them in the paperwork from [name of the transferring hospital] and our physician did not feel there was a need for them (the mittens). LL. On [DATE] at 4:45 pm, during an interview, RT #3 reported if he notices residents having behaviors (restlessness or agitation) or anything else out of the norm, he gets his care completed and then notifies the nurses so that they can address the issues. He reported these residents (with trachs) can't talk, so it's important that we pay attention to what's going on with them. MM. On [DATE] at 10:45 am, during an interview, DON #1 reported that sometimes a residents acuity level (the level of care the resident needs due to their diagnoses or health condition) is too high for the facility to admit them, but that was not determined to be the case with R #1. NN. On [DATE] at 11:04 am, during an interview, the DON #1 reported that a bedside assessment for R #1 should have been conducted by the RD/RT #2, who has since stepped down from her position as Respiratory Director. This assessment is not a written assessment and is also not charted in progress notes. OO. On [DATE] 1:32 pm, during an interview, the DON #1 reported that they do not have a written protocol regarding the pre-admission coordination that happens between the Community Liaison (CL) the nurses and/or other specialized teams such as respiratory. PP. On [DATE] at 5:04 pm, during an interview, the CL reported that part of their process in determining whether or not a resident should be admitted to the facility involves a bedside assessment. She reported that since R #1 was a trach patient, his bedside assessment would have been completed by Respiratory Director (RD)/RT #2. The CL reported that R #1 had no restraints in place (while at the transferring hospital) and there was no specific notation regarding decannulation. The CL reported I knew he was pulling at lines (his trach), but no decannulation and I did not know about the mittens or that he even came over that way (with mittens); maybe they put them on in ambulance. (continued on next page)

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	325045	A. Building B. Wing	11/09/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Princeton Health & Rehabilitation	500 Louisiana Boulevard NE Albuquerque, NM 87108

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	QQ. On [DATE] at 12:34 pm, during an interview, R #1's mother/responsible party (M/RP) reported via translator that she spoke to RN #2 the morning ([DATE]) that R #1 passed away and he told her that R #1 had decannulated himself three times while at the facility and that he decannulated himself again that morning resulting in his death. She reported that she and the rest of R #1's family do not believe that R #1 was fully aware due to his brain injury of what could happen to him as a result of pulling out his trach. R #1's M/RP reported that the family is very upset, because they were never notified that R #1 had been pulling out his trach and they had never witnessed that type of behavior before. 41738

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39822 Based on record review and interview, the facility failed to meet professional standards of quality for 3 (R #11, 12 and 13) of 3 (R #11, 12 and 13) resident's reviewed for lab work obtained, as ordered, to monitor Warfarin [an anticoagulant medication] administrations affect on residents, by not collecting the International Normalized Ratio (INR) [a test used to measure how quickly your blood forms a clot, compared with normal clotting time, 1.0 is normal] as ordered. If the facility is not obtaining INR laboratory [lab] tests as ordered to monitor the affect of Warfarin given, the resident is likely to not get the therapeutic results from the medication, Warfarin and is at increased risk of suffering adverse events such as bleeding or blood clots. The findings are: A. On 10/04/21 at 9:15 am during interview with the Director of Nursing (DON), she revealed that the INR lab results would be found in the Electronic Health Record (EHR). B. Record review of INR orders for R #12 revealed, on 05/03/20 an order to draw INR weekly, every Sunday night. C. Record review of lab results in EHR for R #12 for dates 08/01/21 to 09/30/21 revealed the results available for PT/INRs drawn: 1. 08/02/21 2. 08/09/21 3. 09/19/21 4. 09/26/21 D. On 10/04/21 at 11:20 am, during interview with Medical Records Staff #1 she revealed the PT/INR labs were routinely drawn on Sunday nights in the past but she is not sure what happened to that system. She was able to find orders for the PT/INR draws for R #12 and R #13 but she was not able to locate the results. She is not certain if they were drawn or not at this time. E. On 10/04/21 at 11:30 am during interview with Medical Records Staff #2, he revealed, he used to be able to check on the medical labs web site for results but has been having difficulty accessing that site for a couple of weeks, he is unsure why that is. He was not able to locate additional lab results for R #11 that were not already in the EHR F. Record review of facility provider note dated 08/26/21 [not timed] revealed, Ms.[last name of R #11] is [AGE] years old and has a medical history that includes multiple sclerosis [a disease that makes it hard for the brain to send signals to the nerves in the body], .no longer able to walk or move her legs . She was recently evaluated in the emergency department [of a local hospital], ACT [computerized tomography, a type of radiograph {X-Ray}] . showed a small, nonocclusive [not blocking all flow in the blood vessel] left renal [kidney] vein thrombus [a blood clot] .She was started on anticoagulation [drugs that inhibit the blood from forming clots] therapy. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	G. Record review of census revealed R #11 was sent to the hospital on 08/10/21 at 9:43 am and returned to the facility on [DATE] at 9:20 pm. H. Record review of Provider Orders for R #11 for PT/INR being drawn revealed: 1. On 08/12/21, check PT/INR on Sunday [08/15/21] at bedtime [scheduled at 8:00 pm] 2. On 08/18/21, check PT/INR on Sunday [08/22/21] at bedtime [scheduled at 8:00 pm] 3. On 08/19/21, re-check PT/INR on Sunday [8/22/2021] at bedtime [scheduled at 8:00 pm] 4. On 08/26/21 re-check PT/INR on Friday [8/27/2021] at bedtime [scheduled at 8:00 pm] 5. On 09/01/21 draw PT/INR on Sunday [09/05/21] at bedtime [scheduled at 8:00 pm] I. Record review of medical laboratory PT/INR report, guidance revealed, Recommended Therapeutic range for Monitoring oral [by mouth, such as Warfarin] Anticoagulant Therapy: 2.00 - 3.00 INR [This is the guidance given by the lab for what range the provider should try to dose Warfarin to keep clotting within the range suggested. If INR is less than 2.00 the dose of Warfarin may need to be increased. If the INR is higher than 3. 0 the dose of Wafarin may need to be decreased] J. Record review of PT/INR blood draws and results for R #11 revealed, 1. On 08/18/21 at 3:09 pm, INR 2.98 2. On 08/23/21 at 2:06 pm, INR 1.2 3. On 08/26/21 at 9:10 am, INR 1.15 4. On 08/30/21 at 6:30 pm, INR 1.2 5. On 09/05/21 at 8:40 pm, INR 1.2 6. On 09/12/21 at 11:40 pm, INR 1.5 7. On 09/19/21 at 10:11 am, INR 1.6 8. On 09/26/21 at 5:32 pm, INR 1.6 K. Record review of census document revealed R #12 was initially admitted on [DATE] and was most recently readmitted after a hospital stay on 04/19/21. L. Record review of Provider progress note for R #12, dated 09/16/21 revealed, [AGE] year-old female . Patient is a long-term care resident. She is followed for multiple comorbidities [diseases or medical conditions] . [including] Aortic stenosis [a narrowing of a large blood vessel in the heart] status post mechanical aortic valve [surgery replace a valve in her heart with a mechanical valve] placement on chronic anticoagulation [needs to be on blood anticoagulation medication because her diagnosis just noted put her at increased risk of blood clot formation] (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	M. Record review of medical laboratory INR report, guidance revealed, Suggested INR Therapeutic ranges for Mechanical Prosthetic Valves [such as R #12 has]: 2.5 - 3.5. N. On 10/05/21 at 9:20 am the DON provides INR results that she obtained for dates 08/01/21 - 09/30/21, from the lab that serviced the facility for R #12: 1. On 08/02/21 at 9:08 pm, INR 3.1 2. On 08/09/21 at 9:55 pm, INR 3.3 3. On 09/06/21 at 2:43 pm, INR 3.57 4. On 09/12/21 at 7:45 pm, INR 3.0 5. On 09/19/21 at 11:25 am, INR 2.5 6. On 09/26/21 at 6:38 pm, INR 1.6 O. Record review of face sheet for R #13 revealed he was admitted on [DATE] with a primary diagnosis of Cerebral infarction [Stroke] due to unspecified occlusion [blockage] or stenosis [narrowing] of left middle cerebral artery [blood vessel in brain]. P. Record review of Provider note dated 09/08/21 for R #13 revealed, Patient is a [AGE] year old male with PMH [past medical history] CVA [stroke] and R [right] sided hemiplegia [paralysis or inability to move one side] and hemiparesis [weakness], intracardiac [in the heart] thrombosis, . Q. Record review of Provider orders for PT/INR lab draws for R #13 revealed: 1. On 08/06/21, there was an order for one draw 2. On 08/12/21, an order to draw PT/INR on Sundays [discontinued on 09/08/21] 3. On 09/09/21, an order to draw one time STAT [immediately] R. Record review of PT/INR lab draws and results for R #13 for dates 08/06/21 - 09/30/21 made available by the DON from the medical lab, revealed: 1. On 08/09/21 PT 24.2 and INR 2.11 2. On 08/15/21,PT 21.2 and INR 1.8 3. On 08/19/21, PT 18.9 and INR 1.7 4. On 09/26/21, PT 20.1 and INR 1.7 (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	S. On 10/06/21 at 7:30 am, during interview with the DON, she revealed, We only have 10 residents on Coumadin [Warfarin] so the nurses know who needs to have their blood drawn [for an INR because they are on Warfarin]. They [the staff nurses] have the book [lab orders written, at the desk] so they know [that the lab should be drawn]. She revealed, how these [INR labs] slipped through [the system/were not drawn as ordered] I haven't identified that [yet] and am working on it. T. On 10/06/21 at 8:45 am, during interview with Registered Nurse #4, he revealed that when medical labs are ordered, paper slips get filled out by the unit secretary and the charge nurse or sometimes the staff nurse. They are put in a binder by date of the month that is kept at the nursing desk. If one is missed or not filled out he is not sure how that would be caught and corrected so that the lab is drawn as ordered. The PT/INR's used to drawn on Sunday or Thursday nights but he is not sure if that is still the process.