STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	325043	A. BUILDING _____ B. WING _____	03/27/2015

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CASA ARENA BLANCA NURSING CENTER	205 MOONGLOW AVE. ALAMOGORDO, NM 88310

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 0282 **Level of harm** - Actual harm **Residents Affected** - Few	**Provide care by qualified persons according to each resident's written plan of care.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to follow the written care plan for 1(R #1) of 5 (R #1, #2, #3, #4, and #5) sampled residents on [MEDICATION NAME] ([MEDICATION NAME], a blood thinning medication) by not monitoring her Anticoagulant medication levels through laboratory tests. This deficient practice resulted in Resident #1 having a critical level of blood thinning medication which prevented her blood from clotting effectively after a fall which likely resulted in severe blood loss and death. The findings are: A. Record review of the Physician order [REDACTED].#1 was taking [MEDICATION NAME] ([MEDICATION NAME]) 2.5 mg (milligrams) daily. B. Record review of the care plan dated 11/25/14 revealed Resident requires anticoagulant therapy (anticoagulant medications is administered to a patient to slow the rate at which the patient's blood clots.) The goal of the care plan is Resident will have no active bleeding. The approach indicates the licensed nurse is to coordinate lab work. The licensed nurse and physician are to monitor lab work as ordered. C. Record review of a Laboratory Requisition Form dated 11/25/14 and signed by Physician #1 revealed an order for [REDACTED]. D. Record review of the medical record did not reveal that any laboratory test for PT/INR were ordered by the facility for R #1. E. Record review of the hospital discharge summary for R#1 dated 01/12/15 revealed the date of death was 01/12/15. Final [DIAGNOSES REDACTED]. Primary cause of death is [MEDICAL CONDITION] (bleeding within the skull). 2. Contributing cause is fall and anticoagulation with [MEDICATION NAME]. F. On 03/17/15 at 2:15 pm during an interview with the Director of Nursing she stated, I could not find an order for [REDACTED]. I could not find any orders in the chart. We did not do any labs while she was here.
F 0329 **Level of harm** - Actual harm **Residents Affected** - Few	**1) Make sure that each resident's drug regimen is free from unnecessary drugs; 2) Each resident's entire drug/medication is managed and monitored to achieve highest well being.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to monitor laboratory values for 1 (R #1) of 5 (R #1, #2, #3, #4, and #5) residents on [MEDICATION NAME] ([MEDICATION NAME]; anticoagulant medication). This deficient practice resulted in Resident #1 having a critical level of blood thinning medication which prevented her blood from clotting effectively after a fall which likely resulted in severe blood loss and death. The findings are: A. Record review of a facility Nursing Policies and Procedures dated 03/27/13 revealed the following: 1. Subject : Anticoagulation Monitoring Program 2. Policy: Administration of anticoagulants to patients/residents is based on a defined management program to individualize the care provided to each patient/resident.[MEDICATION NAME] includes a boxed warning. [MEDICATION NAME] can increase the risk of major or fatal bleeding, perform monitoring of INR in all treated patient/residents. 3. Procedures: [MEDICATION NAME] 1) Upon admission or transition of care, [MEDICATION NAME] orders will be reconciled per facility policy for medication reconciliation. 2) Upon admission, a baseline International Normalized Ration (INR) must be drawn unless there is documentation of the most recent INR from the transferring facility. 4) The target INR will be stated with any admission order or any initiation of [MEDICATION NAME] therapy. A.) If target INR is not specified with the order, the nurse will clarify the order. 8. INR's ordered to be drawn per physician's orders [REDACTED]. B. Record review of the medical record for Resident #1 revealed she was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. C. Record review of a Laboratory Flowsheet from the local hospital taken prior to the resident's admission to the facility revealed R #1's PT/INR ([MEDICATION NAME] Time/International Normalized Ratio) laboratory value on 11/24/15 of 47.7 (seconds)/4.2; and on 11/25/15 of 52.5/4.6. The laboratory values for INR on 11/24/15 and 11/25/15 are high values. Normal values for PT is a time of between 10 and 14 seconds and an INR value of 2.0 to 4.0 is the normal clotting time for a person taking anticoagulant medication. D. Record review of a Medication List for discharge meds (medications) from the local hospital revealed [MEDICATION NAME] ([MEDICATION NAME]) 2.5 mg oral tablet. E. Record review of a Laboratory Requisition Form dated 11/25/14 and signed by Physician #1 revealed an order for [REDACTED]. F. Record review of the Physician order [REDACTED].#1 on 01/05/15 revealed a prescription dated 11/26/14 for [MEDICATION NAME] tablet 2.5 mg once a day. G. Record review of a Medications Administration Record (MAR) dated 11/27/15 to 1/11/15 revealed [MEDICATION NAME] 2.5 mg was administered daily. H. Record review of R #1's medical record revealed no record of laboratory values being done while Resident #1 was at the facility. I. On 03/17/15 at 1:10 pm during an interview with Registered Nurse (RN) #2 she stated, I am not sure of the protocol for labs. I think it should be every 2 weeks. The nursing staff is responsible for checking for lab orders. J. On 03/17/15 at 2:00 pm during an interview with the Unit Manager for the 200 hall she stated, I am responsible for checking for lab orders. I don't know why her's (R #1) were not done. K. On 03/17/15 at 2:15 pm during an interview with the Director of Nursing she stated, I could not find an order for [REDACTED]. I could not find any orders in the chart. We did not do any labs while she was here. L. On 03/17/15 at 12:35 pm during an interview with RN #1, she stated, The CNA (Certified Nursing Assistant) (CNA #2) came to get me for help in the ALC (Alternate Level of Care) unit. When I got there she (R#1) was sitting on her bed. The CNA was holding pressure on the laceration on the back of her head. I'm not sure but I think it was on the left side of her head. She had a prior laceration on the back of her head in December. She was in bed, her pillow was bloody. We had a hard time stanching the flow of blood. She was on [MEDICATION NAME]. She worried me. When asked about an order for [REDACTED]. M. Record review of the hospital discharge summary for Resident #1 dated 01/12/15 revealed the date of death was 01/12/15. Final [DIAGNOSES REDACTED]. Primary cause of of death is [MEDICAL CONDITION] (bleeding within the skull). 2. Contributing cause is fall and anticoagulation with [MEDICATION NAME]. N. Record review of a Laboratory Flowsheet from the local hospital dated 01/11/15 revealed R #1's PT/INR ([MEDICATION NAME] Time/International Normalized Ratio) laboratory value was 170.0 (seconds)/10.0. This is a critical value. Normal values for PT is a time of between 10 and 14 seconds and an INR value of 2.0 to 4.0 is the normal clotting time for a person taking anticoagulant medication.
F 0502 **Level of harm** - Actual harm **Residents Affected** - Few	**Give or get quality lab services/tests in a timely manner to meet the needs of residents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to obtain laboratory tests to monitor [MEDICATION NAME] ([MEDICATION NAME], a blood thinning medication) levels for 1 (R #1) of 5 (R #1, #2, #3, #4, and #5) residents on [MEDICATION NAME]. This deficient practice resulted in Resident #1 having a critical level of blood thinning medication which prevented her blood from clotting effectively after a fall which likely resulted in severe blood loss and death. The findings are: A. Record review of a facility Nursing Policies and Procedures dated 03/27/13 revealed the following: 1. Subject : Anticoagulation Monitoring Program 2. Policy: Administration of anticoagulants to patients/residents is based on a defined management program to individualize the care provided to each patient/resident.[MEDICATION NAME] includes a boxed warning. [MEDICATION NAME] can increase the risk of major or fatal bleeding, perform monitoring of INR in all treated patient/residents. 3. Procedures: [MEDICATION NAME] 1) Upon admission or transition of care, [MEDICATION NAME] orders will

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

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.

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F 0502 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 1) be reconciled per facility policy for medication reconciliation. 2) Upon admission, a baseline International Normalized Ration (INR) must be drawn unless there is documentation of the most recent INR from the transferring facility. 4) The target INR will be stated with any admission order or any initiation of [MEDICATION NAME] therapy. A.) If target INR is not specified with the order, the nurse will clarify the order. 8. INR's ordered to be drawn per physician's orders [REDACTED]. B. Record review of the Physician order [REDACTED]. C. Record review the Physician order [REDACTED].#1 was taking [MEDICATION NAME] 2.5 mg (milligrams) daily. D. Record review of a Laboratory Requisition Form dated 11/25/14 and signed by Physician #1 revealed an order for [REDACTED]. E. Record review of a Laboratory Flowsheet revealed R#1 had PT/INR testing done only when at the local hospital emergency roiagnom on [DATE], 11/25/14 and 01/11/15, prior to admission to the facility and after the resident fell , resulting in injury. F. Record review of the medical record did not reveal that any laboratory test for PT/INR were ordered by the facility for R #1. G. Record review of the hospital discharge summary for Resident #1 dated 01/12/15 revealed the date of death was 01/12/15. Final [DIAGNOSES REDACTED]. Primary cause of of death is [MEDICAL CONDITION] (bleeding within the skull). 2. Contributing cause is fall and anticoagulation with [MEDICATION NAME]. H. On 03/17/15 at 2:00 pm during an interview with the Unit Manager for the 200 hall she stated, I am responsible for checking for lab orders. I don't know why hers were not done. I. On 03/17/15 at 2:15 pm during an interview with the Director of Nursing she stated, I could not find an order for [REDACTED]. I could not find any orders in the chart. She did not have any lab tests done while here.