STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045314	A. BUILDING _____ B. WING _____	**08/28/2015**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
RED OAK HEALTHCARE AND REHAB, LLC	**1010 BARNES STREET LONOKE, AR 72086**

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 0159 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Properly hold, secure and manage each resident's personal money which is deposited with the nursing home.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Complaint # (AR 467) was substantiated, all or in part, in these findings. Based on record review and interview, the facility failed to ensure resident funds in the excess of $50.00 continued to have interest applied quarterly until the funds were conveyed to the resident or responsible party after discharge from the facility for 6 of 6 (Resident #s 7, 24 - 28) case mix residents who had trust funds managed by the facility and were discharged from the facility in the last 12 months. This failed practice had the potential to effect 49 residents who had trust funds managed by the facility as documented on a facility Trust-Transaction History report provided by the Human Resource/Payroll/Accounts Payable (HR/PR/AP) person on [DATE]. The findings are: 1. Resident #7 had an initial admission date of [DATE], was discharged to hospital on [DATE], and expired at the hospital on [DATE]. A Facility Trust - Transaction History report dated from [DATE] to [DATE] documented a balance of $3,768.63 in the resident's trust fund account. The funds had not been released to the resident or responsible party, and there was no documentation that interest was posted to the account since the resident's discharge from the facility on [DATE]. 2. Resident #24 had an initial admission date of [DATE] and a transfer date of [DATE]. A Facility Trust - Transaction History report dated from [DATE] to [DATE] documented a balance of $236.57 in the resident's trust fund account. The funds had not yet been released to the resident or responsible party, and there was no documentation that interest was posted to the account since the resident's discharge from the facility on [DATE]. 3. Resident #25 had an initial admission date of [DATE] and a transfer date of [DATE]. The resident expired on [DATE]. Facility Trust - Transaction History dated from [DATE] to [DATE] documented a balance of $1,447.24 in the resident's trust fund account. The funds had not yet been released to the resident or responsible party, and there was no documentation that interest was posted to the account since the resident's discharge from the facility on [DATE]. 4. Resident #26 had an initial admission date of [DATE] and a transfer date of [DATE]. a. A Facility Trust - Transaction History dated from [DATE] to [DATE] documented a balance of $224.82 in the resident's trust fund account. The funds had not yet been released to the resident or responsible party, and there was no documentation that interest was posted to the account since the resident's discharge from the facility on [DATE]. b. On [DATE] at 11:10 a.m. the HR/PR/AP person stated, (Resident #26's) transferred to (another facility name) so I don't know why they did not move his funds then. 5. Resident #27 had an initial admission date of [DATE] and a discharge date of [DATE]. A Facility Trust - Transaction History dated from [DATE] to [DATE] documented a balance of $1,135.00 in the resident's trust fund account. The funds had not yet been released to the resident or responsible party, and there was no documentation that interest was posted to the account since the resident's discharge from the facility on [DATE]. 6. Resident #28 had an initial admission date of [DATE] and a discharge date of [DATE]. A Facility Trust - Transaction History dated from [DATE] to [DATE] documented a remaining balance of $1,860.00 in the resident's trust fund account. The funds had not yet been released to the resident or responsible party, and there was no documentation that interest was posted to the account since the resident's discharge from the facility on [DATE]. 7. On [DATE] at 2:40 p.m., the Administrator stated, I was told that all outstanding accounts were being paid today. A copy of Resident #7's bank statement and copies of checks on outstanding accounts were requested. The Administrator was asked why it took from [DATE] to [DATE] to close Resident #7's account. The Administrator stated, I do not have anything to do with those accounts. It is all done at the Corporate Office. 8. On [DATE] at 11:05 a.m., the HR/PR/AP person was asked, When were you told to write the checks to refund the money to resident/family? The HR/PR/AP person stated, Yesterday by (name of person in Corporate Accounts Receivable). The HR/PR/AP person was asked, What caused corporate to have you write checks. The HR/PR/AP person stated, When we ran the report yesterday for you I told them we still had residents on there with balances in trust and residents had been discharged from facility over 30 days. The HR/PR/AP person was asked, why the discharged residents accounts didn't have interest accumulating. The HR/PR/AP person stated, I do not know. At 11:40 p.m., the HR/PR/AP person was asked if the residents who were discharged still had money in the same bank account and the HR/PR/AP person stated, Yes. The HR/PR/AP person was asked why interest was not being accumulated to the discharged residents' accounts and the HR/PR/AP person stated, I will have to look into the interest print outs. At 12:05 p.m., the HR/PR/AP person stated, It is not that resident accounts did not draw interest. The computer program was set up to apply interest to the active residents only, so corporate is correcting it. 10. A facility Trust Transaction List with a Batch Type: Interest that was dated from [DATE] to [DATE] had no documentation of interest paid to the accounts of the discharged Resident #s 7, 24, 25, 26, 27, and 28.
F 0160 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Follow policies and procedures to convey the resident's personal funds to the appropriate party responsible after the resident's death.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Complaint # (AR 467) was substantiated, all or in part, in these findings. Based on record review and interview, the facility failed to ensure funds of deceased residents were conveyed within 30 days to the individual or probate jurisdictions administering the resident's estates for 2 of 2 (Resident #7 and 25) case mix residents that expired in the past 12 months and had trust funds managed by the facility. This failed practice had the potential to affect 2 residents who expired and had trust funds managed by the facility as documented in list of trust fund accounts provided by the Human Resource/Payroll/Accounts Payable person [DATE]. The findings are: 1. Resident #7 had an initial admission date of [DATE], was discharged to hospital [DATE], and expired at the hospital on [DATE]. A Facility Trust - Transaction History report dated from [DATE] to [DATE] documented a balance of $3,768.63 in the resident's trust fund account. There was no documentation that the funds had been released to the resident or responsible party. 2. Resident #25 had an initial admission date of [DATE], a transfer date of [DATE] and an expiration date of [DATE]. Facility Trust - Transaction History dated from [DATE] to [DATE] documented a balance of $1,447.24 in the resident's trust

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 0160 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 1) fund account. There was no documentation that the funds had been released to the resident or responsible party. 3. On [DATE] at 2:40 p.m., the Administrator stated, I was told that all outstanding accounts were being paid today. A copy of Resident #7's bank statement and copies of checks on outstanding accounts were requested. The Administrator was asked why it took from [DATE] to [DATE] to close resident #7's account and the Administrator stated, I do not have anything to do with those accounts. It is all done at the corporate office. At 3:45 p.m., the Administrator brought copies of checks dated [DATE] to close out Resident #7 and #25's trust fund accounts. The Administrator stated, Corporate wants accounts paid and closed but, wants us to write the checks. These checks are going out tomorrow certified mail. 4. On [DATE] at 11:05 a.m., the HR/PR/AP person was asked, When were you told to write the checks to refund the money to residents' family? The HR/PR/AP person stated, Yesterday by (name of person in corporate Accounts Receivable). The HR/PR/AP person was asked, What caused corporate to have you write checks? The HR/PR/AP person stated, When we ran the report yesterday for you I told them we still had residents on there with balances in trust and residents had been discharged from facility over 30 days.
F 0241 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide care for residents in a way that keeps or builds each resident's dignity and respect of individuality.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview, the facility failed to ensure male facial hair was removed to promote dignity and self-esteem for 1 (Resident #1) of 2 (Residents #1 and #4) male case mix residents who required assistance with shaving. This failed practice had the potential to affect 23 male residents who required assistance with shaving as documented on a list provided by Registered Nurse (RN) # 2 on 10/15/15. The findings are: Resident #1 had [DIAGNOSES REDACTED]. The Significant Change Minimum Data Set with an Assessment Reference Date of 7/27/15 documented a score of 15 (13-15 indicates cognitively intact) on the Brief Interview for Mental Status (BIMS), required set up help only with personal hygiene and was frequently incontinent of urine. a. On 10/12/15 at 3:30 p.m., the resident had a thick growth of facial hair greater than 2 inches in length. b. On 10/13/15 at 11:44 a.m., the resident had a thick growth of facial hair greater than 2 inches in length. The resident was asked, Are you trying to grow a beard or have they just not shaved you? He stated, They just haven't shaved me. I'm supposed to have a shower today. I haven't had a shower in about 3 weeks. They haven't asked me. A few times, I didn't want it right then. They never come back and ask you again if you refuse it at the time they offer. c. On 10/14/15 at 8:20 a.m., the resident had a thick growth of facial hair greater than 2 inches in length. The resident stated, I had a shower last week, but they didn't shave me. He was asked, Did you ask anyone to shave you? He stated, Oh yeah. They will need to get a barber shears now, it is so long. d. On 10/15/15 at 8:20 a.m. the resident had a thick growth of facial hair greater than 2 inches in length. The resident stated, I did not have a bath or shower yesterday. e. On 10/15/15 at 10:45 a.m., the resident was clean shaven. He stated, It took about an hour and 10 razors, but we got it done. I am glad. I feel better. f. On 10/15/15 at 3:07 p.m., Certified Nursing Assistant (CNA) #1 was asked, When are the residents to be shaved? She stated, They are supposed to be shaved with every shower. The CNA was asked, Do you know why the resident hasn't been shaved? She stated, I haven't worked over there; I don't know. The residents would state, 'I don't know' when I asked them about their shaves. I noticed that several needed shaves on the back halls. g. On 10/15/15 at 3:25 p.m., Registered Nurse (RN) #2 was asked, How often should the male residents be shaved? She stated, I think daily or every other day. Their shower day. The RN was asked, Do you know why the male residents haven't been shaved? She stated, They should be, and we need to develop something to make sure they are getting done.
F 0253 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide housekeeping and maintenance services.** br>Complaint # (AR 585) was substantiated, all or in part, in these findings. Based on observation and interview, the facility failed to ensure bathroom drains were not clogged, bathroom tiles and baseboards were in good repair and clean, toilets were clean, bathroom faucets were in good repair, doors did not have gouges, Sharps containers were secured to the wall, and wheelchairs were in good repair and had anti-tipping hardware in place. These failed practices had the potential to effect 55 residents who used wheelchairs according to a list from the Director of Nursing on 8/27/15 and 3 residents on East hall, 11 residents on West hall, and 2 residents on the South as documented on Midnight Census List provided by the Director of Nursing on 8/28/15. The findings are: 1. On 8/23/15, the following observations were made: a. At 12:48 p.m., the bathroom bathtub drain in Resident Room E4 was clogged with a brownish substance and approximately 1/2 inch of standing dirty water was in the bathtub and by the bathroom door jam, at the bottom, 4 (inches) of tile and baseboard were broken and had a brown/black substance on them. b. At 12:48 p.m., in the bathroom in Resident Room E5 approximately 4 from the corner to the left faucet tiles were cracked where the bath wall meets the bathtub. The bathroom toilet and toilet riser seat were covered with a brown substance. c. At 12:49 p.m., in Resident Room E6, the right faucet handle (cold water side) in the bathroom sink was missing. d. At 12:52 p.m., the door to room Resident Room E10 had a gouge approximately 3 by 2 approximately 10 from the bottom of the door on the hinged side. e. At 2:23 p.m. in the West hall shower room, the Sharps container in the wall mount was full; another sharps container was sitting on top of the full container and was not secured to the wall. The unsecured sharps container held a few syringes. f. At 1:33 p.m. in Resident Room S4 there was approximately 3 feet of baseboard missing by the door. g. At 1:35 p.m., in Resident Room S3b the left arm rest on a wheelchair was covered with a pad. There was ragged black electrical-type tape wound around the wheelchair arm rest and threadlike strands were hanging from the arm rest. The rubber on the large left wheel on the wheelchair was pitted and large sections of rubber were eroded and missing. The non-case mix resident stated, They are suppose to get me a new wheelchair. h. At 2:16 p.m., in Resident Room C9 there was a wheelchair that the right arm rest covering was cracked and tearing away. The wheelchair had an anti-tipping device on the left side that was missing an endcap, the right side of the wheelchair did not have a anti-tipping device in place. 2. On 8/27/15 at 10:20 a.m., the DON was taken to the West hall shower room. The sharps container in the wall mount was still full with the other sharps container setting on top unsecured. The unsecured sharps container was 25% full of syringes and razors.
F 0329 **Level of harm** - Immediate jeopardy **Residents Affected** - Some	**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** Complaint # (AR 585) and # (AR 590) were substantiated, all or in part, in these findings. A. Based on observations, record review and interview, the facility failed to ensure high risk medications ([MEDICATION NAME]) were monitored for potential toxic levels and were given or held as prescribed by the physician to ensure accuracy of using lab results to determine most effective dose for 3 of 3 (Residents #17, #11 and #12) case mix residents who received anticoagulant therapy. The failed practice resulted in Immediate Jeopardy which caused or could have caused serious harm, injury or death to 1 (Resident #17) who expired [DATE] with a critically high INR and 2 (Residents #11 and #12) who had orders for [MEDICATION NAME] and no consistent PT/INR ([MEDICATION NAME] Time/International Normalized Ratio) monitoring. The failed practice had the potential to cause more than minimal harm for 5 residents who received anticoagulant therapy. The facility was notified of the Immediate Jeopardy on [DATE] at 9:53 a.m. The findings are: 1. Resident #17 had [DIAGNOSES REDACTED]. The Significant Change Minimum Data Set (MDS) with an Assessment Reference Date

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F 0329

Level of harm - Immediate jeopardy

Residents Affected - Some

(continued... from page 2)
(ARD) of [DATE] documented the resident scored 15 (,[DATE] cognitively intact) on a Brief Interview for Mental Status (BIMS); was independent with activities of daily living, and received anticoagulant therapy 2 days of the past 7 days.
a. A physician's order dated [DATE] documented, Warfare Sodium 6 mg (milligrams) give 1 tablet by mouth one time a day for [MEDICAL CONDITION] give with 7.5 mg tab = (equals) 13.5 mg. Another physician's order dated [DATE] documented, [MEDICATION
NAME] Sodium tablet 7.5 mg give 1 tablet one time a day for [MEDICAL CONDITION]. Give with 6 mg to = 13.5 mg.
b. The temporary plan of care for the resident dated [DATE] did not address the Anticoagulant therapy or the risk factors associated with anticoagulant therapy.
c. The [DATE] Medication Administration Record [REDACTED]. The MAR indicated [REDACTED]. The MAR indicated [REDACTED]. One
time only for therapeutic levels for 1 day. This was administered one time on [DATE]. However, there was no physician order in the clinical record to do this.
d. The [DATE] MAR indicated [REDACTED]. The [DATE] MAR indicated [REDACTED].
e. A PT/INR results dated [DATE] documented the [MEDICATION NAME] as 49 (10XXX,[DATE].1 normal range) and the INR as 4.45
(0XXX,[DATE].2 normal range). The physician wrote on the lab sheet to hold ([MEDICATION NAME]) and repeat (PT/INR) in 3 days.
f. On [DATE] the PT/INR was drawn and the results were [MEDICATION NAME] 15.8 and the INR as 1.39. The physician wrote on the lab slip to increase to 11 mg for one week and then repeat the INR. (The [DATE] MAR indicated [REDACTED]
A physician's telephone order dated [DATE] documented, [MEDICATION NAME] 11 mg po (oral) x (times) 1 week and repeat PT/INR
as scheduled. The [DATE] MAR indicated [REDACTED].
g. The next PT/INR's were drawn on [DATE], [DATE], and [DATE] and the physician initialed the lab slips.
A telephone order that was not dated documented, Increase [MEDICATION NAME] 10.5 mg x one week and repeat PT/INR x 7 days.
h. Nurses notes dated [DATE] at 7:53 p.m., documented, Lab results called to on call APN (Advanced Practice Nurse) at 12:40 p.m. No N.O. (new orders) received at this time. Resident later observed to be lethargic VS (vital signs) 100.3, 85, 20 ,[DATE], pulse ox 70 to 93% on O2 (oxygen). Order received to TF (transfer) to hospital. EMS (Emergency Medical Services) notified of transfer at 1:56 a.m.
i. On [DATE] the resident was readmitted to the facility with orders for [MEDICATION NAME] 7.5 mg give 2 tablets to = 15 mg and [MEDICATION NAME] 06 mg/0.6Ml (milliliter) - give 0.6 ml SQ (subcutaneous) daily. PT/INR daily until INR is between 2.0 - 3.0, then once therapeutic level reached D/C (discontinue) [MEDICATION NAME].
The [DATE] MAR indicated [REDACTED]. The [DATE] MAR indicated [REDACTED]. However, the pharmacy stated that they sent out 7
doses on [DATE].
j. The next PT/INR dated [DATE] documented INR of 1.85. The physician hand wrote an order Increase to 15.5 mg daily x 7 days and repeat PT/INR.
The August [DATE] documented the resident received 15 mg of [MEDICATION NAME] instead of 15.5 mg from [DATE] - [DATE],
[DATE], and [DATE] - [DATE] at 5 p.m. (held on [DATE], [DATE], and [DATE]). The MAR indicated [REDACTED].
k. The next PT/INR was drawn on [DATE] and the INR was documented as 1.94.
A physician's order dated [DATE] to documented, D/C (discontinue) [MEDICATION NAME] R/T (related to) INR 2.3. (INR results was 1.94 not 2.3)
l. The PT/INR results dated [DATE] documented the INR was 3.16. The PT/INR results dated [DATE] documented the INR as 4.04. There was no documentation on the lab sheet or the nurses notes that the physician or APN was notified of these results.
A physician's order dated [DATE] at 10:06 a.m. documented to hold [MEDICATION NAME] for 2 days. Note: The [DATE] MAR indicated [REDACTED].
m. Nurses notes dated [DATE] at 5:54 p.m., documented, At 4:55 p.m., call placed to on-call APN and report given of concern about [MEDICATION NAME] dose with last INR greater that 4.0 (the one done on [DATE]). Received order to send R (resident) to ER (emergency room) for PT/INR lab draw. Order noted DON (Director of Nursing) and Administrator notified of TF (transfer) order. R (Resident) informed order to TF to ER (emergency room) for lab draw, and the need to find out where the current INR was before resuming dose. R made informed decision to refuse TF for lab draw. At 5:09 p.m., APN informed of R's refusal to TF out for lab. Received order to hold [MEDICATION NAME] until lab draw results received tomorrow. FU (follow-up) with on-call. Note: The [DATE] MAR indicated [REDACTED].
n. Nurses notes dated [DATE] at 6:55 p.m., documented, CNA (Certified Nursing Assistant) reported R was not breathing. Observed R in bed, w/o (with-out) respiration or pulse. Code Blue room [ROOM NUMBER] east paged over intercom. Call placed to (local ambulance service) report given this is (LPN) at (name of facility) (address of facility), I have a code blue situation in room [ROOM NUMBER] east. It is a bariatric patient send assistance. CPR initiated, EMS (emergency medical services) arrived, report given R TF to stretcher per staff and EMS. R out of building at 7:13 p.m. (family member) notified of TR at 7:15 p.m. Report called to (initials of hospital), Dr (name) notified of pronouncement at 8:19 p.m APN notified at 8:20 p.m
o. A lab result collected on [DATE] at 1:10 p.m. documented INR of 6.02 High and [MEDICATION NAME] 53.4 High. This form documented, Results successfully called to (initials of lab contracted by the facility) at 8:21 p.m.
On [DATE] at 4:00 p.m., the Director of Nurses stated she called the lab and they told her that the reason the facility was not notified of the High INR was that they had no telephone number or anyway to contact the facility.
2. Resident # 11 had a [DIAGNOSES REDACTED]. The Annual MDS with ARD of [DATE] documented the resident scored of 6 (,[DATE]
indicates severely impaired) on the BIMS, required limited assistance with bed mobility and extensive assistance with dressing, was independent with the remainder of activities of daily living and received an anticoagulant 7 of the past 7 days.
a. The Plan of Care developed [DATE] documented a problem of, The resident is on anticoagulant Therapy [MEDICATION NAME] with interventions that included Administer Anticoagulant medications as ordered by the physician and Labs as ordered. Report abnormal lab results to MD.
b. A physician's order dated [DATE] documented, [MEDICATION NAME] 4 mg daily x 1 week. Repeat PT/INR as scheduled.
c. A Lab report dated [DATE] documented the PT ([MEDICATION NAME]) as 17.8 and the INR as 1.57. There was a physician's order dated [DATE] to increase the [MEDICATION NAME] to 5 mg daily and continue weekly PT/INR. The [DATE] MAR indicated
[REDACTED].
d. A physician's order dated [DATE] documented, Increase [MEDICATION NAME] to 5.5 mg daily and repeat PT/INR in 7 days.
e. The next PT/INR was drawn on [DATE] (5 days later than when ordered).
f. The [MEDICATION NAME] results dated [DATE] documented 40.3 and the INR was 3.64. There was a hand written order on the lab slip that documented, Hold PT/INR ([MEDICATION NAME]? not clarified by facility) x 2 days and repeat PT/INR. The [DATE]
MAR indicated [REDACTED].
g. A physician's order dated [DATE] documented, D/C (discontinue) [MEDICATION NAME] 5.5 mg and start [MEDICATION NAME] 4 mg
one po at 5:00 p.m. and redraw PT/INR on [DATE].
h. The next PT/INR was drawn on [DATE], four days later than ordered.
3. Resident #12 had a [DIAGNOSES REDACTED].
a. The Plan of Care updated on [DATE] documented a problem of, Daily anticoagulant as per MD orders for CAD ([MEDICAL CONDITION]) with potential for easily bleeding and or bruising with interventions that included Administer meds as ordered, obtain and monitor/diagnostic work as ordered. Report results to MD and follow-up as ordered.
b. A physician's order dated [DATE] documented, Increase [MEDICATION NAME] to 10 mg daily for 7 days and Repeat PT/INR as scheduled.
c. Lab results dated [DATE] documented [MEDICATION NAME] 15.3 and INR 1.34. There was a hand written order on the form to increase [MEDICATION NAME] to 10.5 mg daily and repeat PT/INR in 7 days.
The [DATE] MAR indicated [REDACTED].
The [DATE] MAR indicated [REDACTED].
d. On [DATE] at 2:00 p.m., the resident's medication from the cart was reviewed. There was only one card of [MEDICATION NAME] 10 mg in the cart.
On [DATE] at 11:25 a.m., the pharmacy tech stated that the [MEDICATION NAME] 0.5 mg was sent out on the 11th. She further stated that they send enough for 7 doses and then received information from the facility that it was discontinued on [DATE].
There was no documentation in the nurses notes or lab slips that the dose was decreased to 10 mg. The [DATE] MAR indicated

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F 0329

Level of harm - Immediate jeopardy

Residents Affected - Some

(continued... from page 3)
[REDACTED].
e. The next PT/INR was drawn on [DATE] instead of on the 17th as ordered.
4. On [DATE] at 4:00 p.m., the Director of Nurses stated that lab company had notified her on [DATE] that they would no longer draw lab because they had not been paid. She stated that she called the corporate office and they told her, You are there, you handle it. She stated that she notified the local hospitals and they would not do it. She stated that she then called the Health Department and they told her that she would need more training. She stated she found a business card for the lab services that were now contracted with the facility.
5. According to the Nursing 2015 Drug Handbook, [MEDICATION NAME] is a Anticoagulants. For Administration of oral [MEDICATION NAME] PT/INR determinations are essential for proper control. The black Box warning documented [MEDICATION
NAME] can cause major or fatal bleeding. Regularly monitor INR in all patients.
6. The Immediate Jeopardy was removed , and the Scope/Severity was lowered to an H on [DATE] at 3:00 p.m., when the facility implemented the following plan of removal.
a. The Director of Nursing/Assistant Director of Nursing and RN (Registered Nurse) Treatment Nurse were inserviced on the protocol for PT/INR and the PT/INR deviation sheet by the Corporate Quality Improvement Coordinator on [DATE] at 11:00 a.m. The inservice included verification by the nurse that the results of the PT/INR were confirmed before giving the medication and if the lab was out of parameters or there was no results then they are to contact the physician to determine medication order for [MEDICATION NAME] and other items noted.
b. Each of the five (5) residents medical records, who are on anticoagulation therapy were checked by Assistant Director of Nursing and/or RN Treatment nurse on [DATE] from 2:30 p.m., to 4:00 p.m. for correct orders, electronic medical record and medication cart accuracy.
c. All resident receiving [MEDICATION NAME] were assessed on [DATE] from 11:15 a.m. to 2:26 p.m. by the Assistant Director of Nursing and/or Registered Nurse treatment nurse with no abnormal findings.
d. The medication carts (3) were audited for correct [MEDICATION NAME] dosages for the five (5) residents on [DATE] by the Assistant Director of Nursing and/or RN Treatment Nurse
e. The PT/INR deviation sheet was put into use by the Assistant Director of Nurses and/or RN Treatment nurse on [DATE] at 11:15 a.m. All nurses working the current shift were inserviced on the PT/INR deviation sheet by the Assistant Director of Nurses and/or RN Treatment Nurse on [DATE] at 11:15 a.m. The inservice included verification by the nurse that the results of the PT/INR were confirmed before giving the medication and if the lab was out of parameters or there was no results then they are to contact the physician to determine medication order for [MEDICATION NAME] and other items noted. All other licensed nurses will be inserviced by the Assistant Director of Nurses and/or RN Treatment Nurse before beginning his/her assigned shift and outgoing to include new employees and any employees returning from leave or absence.
f., The physician, Medical Director, was contacted on [DATE] at 11:30 a.m., by the Director of Nursing for all residents on anticoagulation therapy and an order was obtained to draw PT/INR. The lab company was contacted by the Director of Nursing and on [DATE] arrived in the facility to draw stat PT/INR's on all residents on anticoagulation therapy on [DATE] at 3:00 p.m.
g. The pharmacy was notified by the Director of Nursing on [DATE] and arrived at 2:00 p.m., of issue and a consultant pharmacist conducted an audit of all medications to assure appropriate labs are being drawn for therapeutic medication levels
h. The Director of Nursing and/or Assistant Director of Nursing will audit all [MEDICATION NAME] orders dosages given and any labs associated with [MEDICATION NAME] for 3 months. The DON/ ADON will audit 5 x week for 3 months starting on [DATE].
Results from audit will be presented at the monthly QAPI meeting for further evaluation and any abnormal findings will immediately be corrected and reported to Administrator and Medical Director.

B. Based on observation, record review and interview, the facility failed to ensure that laboratory work was performed to monitor for potentially harmful blood dyscrasias and to ensure pharmacy could continue to send the medication for 3 of 3 (Resident #13, #21, #22) case mix residents who had orders for [MEDICATION NAME]. This failed practice had the potential to cause more than minimal harm for 3 residents in the facility who had orders for [MEDICATION NAME] according to the list provided by the Director of Nursing on [DATE].
The findings are:
1. Resident #13 had [DIAGNOSES REDACTED].
a. The Order Summary Report for [DATE] documented, [MEDICATION NAME] tablet 100 mg: Give 1.5 tablet by mouth at bedtime .
(start date [DATE]). [MEDICATION NAME] tablet 50 mg. Give 1 tablet by mouth one time a day . (start date [DATE]) . CBC (complete blood count) with diff (differential) with absolute neuraphil (sic) count weekly x 6 months. Start Date [DATE].
b. The clinical record had copies of lab results for a CBC with Diff that was performed on [DATE], [DATE], [DATE] and [DATE]. There were no results in the record for any CBC with Diff after [DATE], order would not have been discontinued until [DATE].
c. The [DATE] MAR indicated [REDACTED]. The MAR indicated [REDACTED].
d. The [DATE] MAR indicated [REDACTED]. The MAR indicated [REDACTED].
e. The electronic medical record progress notes were reviewed on [DATE] and documented as follows:
[DATE] 21:52 (9:52 p.m.) WBC (White Blood Count) (with) Diff (differential) faxed to Central Pharmacy.
[DATE] 21:15 (9:15 p.m.) [MEDICATION NAME] (sic) not available.
[DATE] 9:06 a.m. Unavailable at this time.
[DATE] 9:07 a.m. Unavailable at this time.
f. On [DATE] at 8:45 a.m., Registered Nurse (RN) #1 was asked, Why are there skips in the [MEDICATION NAME] (administration)? RN #1 stated, I'm not sure why. [MEDICATION NAME] is an antipsychotic and needs a CBC. Copies of the CBC with diff performed since [DATE] were requested but not provided by the time of exit.
2. Resident # 22 had [DIAGNOSES REDACTED]. The Admission MDS with an ARD of [DATE] documented the Resident scored 11
(,[DATE] indicates moderately impaired) on the BIMS; had inattention and disorganized thinking that fluctuated; had no behaviors; and received antipsychotic, antianxiety, antidepressant and hypnotic drugs daily.
a. The Plan of Care created on [DATE] documented, Focus: (Name of Resident) has a potential for adverse side effects d/t (due to) daily use of antipsychotic as per MD orders for her DX (diagnosis) of [MEDICAL CONDITION] and [MEDICAL CONDITION]
Disorder; . Interventions: Administer anti-psychotic as per MD order monitoring and observing for adverse side effects, notifying MD as indicated .
b. The Order Summary Report for [DATE] documented, [MEDICATION NAME] tablet: Give 150 mg by mouth at bedtime . (Start date
[DATE]) . [MEDICATION NAME] tablet: Give 50 mg by mouth in the morning . (Start date [DATE]) .
There were no documented orders for a CBC with Differential to be drawn weekly to monitor for blood dyscrasias with [MEDICATION NAME].
c. A CBC with Diff dated [DATE] was in the clinical record. There were no results for any CBC with Diff in the record since that date.
d. The [DATE] MAR indicated [REDACTED].
e. The [DATE] MAR indicated [REDACTED].
f. The electronic medical record progress notes documented as follows:
[DATE] 6:25 a.m. Refused AM (morning) meds.
[DATE] 20:01 (8:01 p.m.) Blood drawn - have not received med. (medication) from pharmacy.
[DATE] 00:58 (a.m.) . Resident up in w/c (wheelchair) in DR (dining room) at this time. Talking to people that are not there. Also making loud animal sounds and screaming at herself.
[DATE] 21:13 (9:13 p.m.) [MEDICATION NAME] (sic) not available.
[DATE] 05:49 (a.m.) [MEDICATION NAME] (sic) not available.
[DATE] 05:53 (a.m.) Not available.
g. On [DATE] at 8:45 a.m., RN #1 was asked for copies of any CBC with Diff since the date on the results in the clinical record, but copies were not provided by the time of exit.
3. Resident #21 had [DIAGNOSES REDACTED].
a. The [DATE] Order Summary Report documented, [MEDICATION NAME] Tablet 100 mg 3.5 tablets by mouth at bedtime . CBC Q week

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	045314	A. BUILDING _____ B. WING _____	**08/28/2015**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
RED OAK HEALTHCARE AND REHAB, LLC	**1010 BARNES STREET LONOKE, AR 72086**

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 0329 **Level of harm** - Immediate jeopardy **Residents Affected** - Some	(continued... from page 4) every day shift every Mon (Monday) for [MEDICATION NAME] Refill. b. The Plan of Care revised on [DATE] documented, Focus: (Name of Resident) has a potential for adverse side effects d/t daily use of antipsychotic as per MD orders for his dx of [MEDICAL CONDITION]. Interventions: Administer antipsychotic medication as ordered by physician. Monitor for side effects and effectiveness . c. A CBC with Diff dated [DATE] was in the resident's clinical record. There were no results for any other CBC performed in the record since that date. d. The [DATE] MAR indicated [REDACTED]. e. The electronic medical record progress notes were reviewed and documented as follows: [DATE] 19:57 (7:57 p.m.) Unable to administer. [MEDICATION NAME] (sic) not available. [DATE] 20:11 (8:11 p.m.) Gamma Lab here to venipuncture resident for CBC. [DATE] 23:57 (11:57 p.m.) Received results of CBC/diff and was faxed to (Name of pharmacy). [DATE] 20:06 (8:06 p.m.) Blood drawn - haven't received med from pharm (pharmacy). [DATE] 21:11 (9:11 p.m.) Scheduled lab not drawn nor scheduled [MEDICATION NAME] not available at this time. f. On [DATE] at 8:45 a.m., RN #1 was asked for copies of any CBC with Diff since the date on the results ([DATE]) in the clinical record, but copies were not provided by the time of exit. 4. On [DATE] at 4:00 p.m., the Director of Nurses stated that lab company had notified her on [DATE] that they would no longer draw lab because they had not been paid. She stated that she called the corporate office and they told her You are there, you handle it. She stated that she notified the local hospitals and they would not do it. She stated that she then called the Health Department and they told her that she would need more training. She stated that she found a business card for the lab services that are now contracted with the facility. 5. On [DATE] at 1:53, a telephone interview with a pharmacy representative from Pharmacy #1 was conducted. Pharmacist #1 was asked, Is there a reason the [MEDICATION NAME] was not sent to the residents? Pharmacist #1 stated, Probably the blood work. Pharmacist #1 was asked, Do they (the facility) fax the blood work to the pharmacy and then you dispense? The Pharmacist stated, We enter the blood work into a national [MEDICATION NAME] database. We can't dispense it unless we have a CBC with differential.
F 0332 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Keep the rate of medication errors (wrong drug, wrong dose, wrong time) to less than 5%.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Complaint # (AR 585) was substantiated, all or in part, in these findings. Based on observation of the medication passes at 8:00 a.m., 12:00 noon, 4:00 p.m. on 8/24/15 and the 8:00 a.m. and 12:00 noon medication pass on 8/25/15, record review and interview, the facility failed to ensure the medication error rate was less than 5%. physician's orders [REDACTED].#15, #18, #19, #20) of 12 case mix residents observed during the medication passes resulting in errors. Medication errors were made by 4 Licensed Practical Nurse (LPN) #1, LPN #2, LPN #3, and Registered Nurse (RN) #1) of 4 nurses observed administering medications with errors made on 3 of the 4 halls observed. This failed practice had the potential to affect 11 residents who resided on the West hall, 20 residents who resided on the South Hall, and 18 residents who resided on the Central Hall according to the census list provided by the Director of Nursing on 8/28/15. The medication error rate was 11.36 % based on administration of 44 opportunities and 5 errors observed. The findings are: 1. Resident #15 had [DIAGNOSES REDACTED]. a. The Order Summary Report for August 2015 documented, Insulin Regular Human Solution. Inject as per sliding scale: if 150-198 = 3 units; 200 - 249 = 5 units; 250 - 299 = 7 units; 300 - 349 = 9 units; 350 - 399 = 11 units. Notify provider for FSBS (Finger Stick Blood Sugar) less than 70 mg (milligrams)/dl (deciliter) and greater than 400 mg/dl, subcutaneously before meals and at bedtime for Diabetes Mellitus Insulin Regular [MEDICATION NAME] Solution. b. On 8/24/15 at 8:20 a.m., LPN #1 performed a finger stick blood sugar on Resident #15 with a result of 315. The physician's orders [REDACTED]. LPN #1 stated, I'm going to call the MD or Nurse Practitioner and let them know the resident is scheduled to get the blood sugars after the meal. The sliding scale insulin was not given to the resident. LPN #1 stated, I didn't have the insulin (the resident) needs in the building. 2. Resident #18 had [DIAGNOSES REDACTED]. a. The Order Summary Report for August 2015 documented, Refresh Tears Solution . Instill 1 drop in both eyes two times a day. b. During observation of the 8:00 a.m. medication pass, RN #1 did not instill eye drops in the resident's eyes because there was none in the medication cart. RN #1 was asked, Is there a reason the Refresh Tears was allowed to run out? RN #1 stated, I'm not 100% sure on that. 3. Resident #15 had the [DIAGNOSES REDACTED]. a. The Order Summary Report for August 2015 documented, [MEDICATION NAME] HCL ([MEDICATION NAME]) Tablet 25 mg Give 3 tablets by mouth three times a day. b. During the observation of the 4:00 p.m. medication pass, LPN #2 administered one [MEDICATION NAME] 25 mg tablet to the resident. LPN #2 was asked, How many [MEDICATION NAME] did you give the resident? LPN #2 stated, One. LPN #2 was asked, How many does the orders say (to give)? LPN #2 stated, Three. Oh, man, I messed up. 4. Resident #19 had [DIAGNOSES REDACTED]. a. The August 2015 Order Summary Report documented, [MEDICATION NAME] Tablet 10 mg ([MEDICATION NAME] Beselate) give 1 tablet by mouth one time a day related to . hypertension. b. During the observation of the 8:00 a.m. medication pass on 8/25/15, RN #1 did not punch the [MEDICATION NAME] Beselate into the medication cup to give to the resident. RN #1 was asked, How many pills are in the cup? RN #1 stated, 4. RN #1 was asked, I didn't see you punch the Amlodopine into the medicine cup. RN #1 reviewed the medication cards and was asked, Which medication is missing from the cup? RN #1 stated, [MEDICATION NAME]. 5. Resident #20 had [DIAGNOSES REDACTED]. a. The August 2015 Order Summary Sheet documented, [MEDICATION NAME] Tablet 200 mg Give 1 tablet by mouth three times a day related to Generalized [MEDICAL CONDITION] . Give with food & (and) adequate fluid. b. During the observation of the 12:00 noon medication pass, LPN #7 went to the resident's room at 11:10 a.m. and administered [MEDICATION NAME] 200 mg with no food and 6 ounces of water. LPN #7 asked the resident if she wanted to get up for lunch, and when the resident started to get up, LPN #7 stated, It will be another hour, I'll have the girls help you then. The resident was checked at 11:50 a.m., and 12:12 p.m. and no tray was served. The resident was served a tray at 12:20 p.m., one hour and 10 minutes after the [MEDICATION NAME] was administered. At 12:10 p.m., LPN #7 was asked, If a medication says 'give with food', what does that mean? LPN #7 stated, Give it with a meal tray.

F 0333 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	**Make sure that residents are safe from serious medication errors.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Complaint # (AR 585) and # (AR 590) were substantiated, all or in part, in these findings. A. Based on observations, record review and interview, the facility failed to ensure Residents #17, #11, and #12 were free of significant medication errors. The facility failed to ensure [MEDICATION NAME] (a high risk medication) was administered or held per the physician's order 3 of 3 (Residents #17, #11 and #12) case mix residents who received anticoagulant therapy. The failed practice resulted in Immediate Jeopardy which caused or could have caused serious harm, injury or death to 1 (Resident #17) who expired [DATE] with a critically high INR and 2 (Residents #11 and #12) who had orders for [MEDICATION NAME] and no consistent PT/INR ([MEDICATION NAME] Time/International Normalized Ratio) monitoring. The failed practice had the potential to cause more than minimal harm 5 residents received anticoagulation therapy. The facility was notified of the Immediate Jeopardy on [DATE] at 9:53 a.m. The findings are: 1. Resident #17 had [DIAGNOSES REDACTED]. The Significant Change Minimum Data Set (MDS) with an Assessment Reference Date of [DATE] documented the resident scored 15 (a score of ,[DATE] indicates cognitively intact) on the Brief Interview for Mental Status (BIMS); was independent with activities of daily living, and received anticoagulant therapy 2 days of the past 7 days. a. A physician's order dated [DATE] documented, Warfare Sodium 6 mg (milligrams) give 1 tablet by mouth one time a day for [MEDICAL CONDITION] give with 7.5 mg tab = (equals) 13.5 mg. Another physician's order dated [DATE] documented, [MEDICATION

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F 0333

Level of harm - Immediate jeopardy

Residents Affected - Some

(continued... from page 5)
NAME] Sodium tablet 7.5 mg give 1 tablet one time a day for [MEDICAL CONDITION]. Give with 6 mg to = 13.5 mg.
b. The [DATE] Medication Administration Record [REDACTED]. The MAR indicated [REDACTED]. The MAR indicated [REDACTED]. One
time only for therapeutic levels for 1 day. This was administered one time on [DATE]. However, there was no physician order in the clinical record to do this.
d. The [DATE] MAR indicated [REDACTED]. The [DATE] MAR indicated [REDACTED].
e. A PT/INR results dated [DATE] documented the [MEDICATION NAME] as 49 (10XXX,[DATE].1 normal range) and the INR as 4.45
(0XXX,[DATE].2 normal range). The physician wrote on the lab sheet to hold ([MEDICATION NAME]) and repeat (PT/INR) in 3 days.
f. The PT/INR was drawn on [DATE] and the results were [MEDICATION NAME] 15.8 and the INR as 1.39. The physician wrote on
the lab slip to increase to 11 mg for one week and then repeat the INR. (The [DATE] MAR indicated [REDACTED]
A physician's telephone order dated [DATE] documented [MEDICATION NAME] 11 mg po (oral) x (times) 1 week and repeat PT/INR
as scheduled. The [DATE] MAR indicated [REDACTED].
g. The next PT/INR's were drawn on [DATE], [DATE] and [DATE] and the physician initialed the lab slips.
A telephone order that was not dated documented, Increase [MEDICATION NAME] 10.5 mg x one week and repeat PT/INR x 7 days.
h. Nurses notes dated [DATE] at 7:53 p.m., documented, Lab results called to on call APN (Advanced Practice Nurse) at 12:40 p.m. No N.O. (new orders) received at this time. Resident later observed to be lethargic VS (vital signs)100.3, 85, 20 ,[DATE], pulse ox 70 to 93% on O2 (oxygen). Order received to TF (transfer) to hospital. EMS (Emergency Medical Services) notified of transfer at 1:56 a.m.
i. The resident was re-admitted to the facility on [DATE] with orders for [MEDICATION NAME] 7.5 mg give 2 tablets to = 15 mg and [MEDICATION NAME] 06 mg/0.6Ml (milliliter) - give 0.6 ml SQ (subcutaneous) daily. PT/INR daily until INR is between 2.0 - 3.0, then once therapeutic level reached D/C (discontinue) [MEDICATION NAME].
The [DATE] MAR indicated [REDACTED]. The [DATE] MAR indicated [REDACTED]. However, the pharmacy stated that they sent out 7
doses on [DATE].
j. The next PT/INR dated [DATE] documented INR of 1.85. The physician hand wrote an order Increase to 15.5 mg daily x 7 days and repeat PT/INR.
The [DATE] MAR indicated [REDACTED]. The MAR indicated [REDACTED].
k. The next PT/INR was drawn on [DATE] and the INR was documented as 1.94.
A physician's order dated [DATE] documented, D/C (discontinue) [MEDICATION NAME] R/T (related to) INR 2.3. (INR results was
1.94 not 2.3)
l. The PT/INR results dated [DATE] documented the INR at 3.16. The PT/INR results dated [DATE] documented the INR as 4.04. There was no documentation on the lab sheet or the nurses notes that the physician or APN was notified of these results.
A physician's order dated [DATE] at 10:06 a.m. documented to hold [MEDICATION NAME] for 2 days. Note: The [DATE] MAR indicated [REDACTED].
m. Nurses notes dated [DATE] at 5:54 p.m., documented, At 4:55 p.m., call placed to on-call APN and report given of concern about [MEDICATION NAME] dose with last INR greater that 4.0 (the one done on [DATE]). Received order to send R (resident) to ER (emergency room) for PT/INR lab draw. Order noted DON (Director of Nursing) and Administrator notified of TF (transfer) order. R (Resident) informed order to TF to ER (emergency room) for lab draw, and the need to find out where the current INR was before resuming dose. R made informed decision to refuse TF for lab draw. At 5:09 p.m., APN informed of R's refusal to TF out for lab. Received order to hold [MEDICATION NAME] until lab draw results received tomorrow. FU (follow-up) with on-call. Note: The [DATE] MAR indicated [REDACTED].
n. Nurses notes dated [DATE] at 6:55 p.m., documented, CNA (Certified Nursing Assistant) reported R was not breathing. Observed R in bed, w/o (with-out) respiration or pulse. Code Blue room [ROOM NUMBER] east paged over intercom. Call placed to (local ambulance service) report given this is (name of LPN) at (name of facility) (address of facility), I have a code blue situation in room [ROOM NUMBER] east. It is a bariatric patient send assistance. CPR initiated, EMS arrived, report given R TF to stretcher per staff and EMS. R out of building at 7:13 p.m. (name of family member) notified of TR at 7:15 p.m. Report called to (initials of hospital), Dr (name) notified of pronouncement at 8:19 p.m. APN notified at 8:20 p.m.
o. A lab results collected on [DATE] at 1:10 p.m. documented INR of 6.02 High and [MEDICATION NAME] 53.4 High. This form documented, Results successfully called to (initials of lab contracted by the facility) at 8:21 p.m.
2. Resident #11 had a [DIAGNOSES REDACTED]. The Annual MDS with ARD of [DATE] documented the resident scored of 6 (,[DATE]
indicates severe impairment) on a BIMS, required limited assistance with bed mobility and extensive assistance with dressing, was independent with the remainder of activities of daily living, and received an anticoagulant 7 days in the past 7 days.
a. The Plan of Care developed [DATE] documented a problem of, The resident is on anticoagulant Therapy [MEDICATION NAME] with interventions that included Administer Anticoagulant medications as ordered by the physician and labs as ordered. Report abnormal lab results to MD.
b. A physician's order dated [DATE] documented, [MEDICATION NAME] 4 mg daily x 1 week. Repeat PT/INR as scheduled.
c. A lab report dated [DATE] documented the PT ([MEDICATION NAME]) as 17.8 and the INR as 1.57. There was a physician's order dated [DATE] to increase the [MEDICATION NAME] to 5 mg daily and continue weekly PT/INR. The [DATE] MAR indicated
[REDACTED].
d. A physician's order dated [DATE] documented, Increase [MEDICATION NAME] to 5.5 mg daily and repeat PT/INR in 7 days.
e. The next PT/INR was drawn on [DATE] (5 days later than when ordered).
f. On [DATE] the [MEDICATION NAME] was 40.3 and the INR was 3.64. There was a hand written order on the lab slip that documented, Hold PT/INR ([MEDICATION NAME]? not clarified by facility) x 2 days and repeat PT/INR. The [DATE] MAR indicated
[REDACTED].
g. A physician's order dated [DATE] documented, D/C (discontinue) [MEDICATION NAME] 5.5 mg and start [MEDICATION NAME] 4 mg
one po at 5:00 p.m. and redraw PT/INR on [DATE].
h. The next PT/INR was drawn on [DATE], four days later than ordered.
3. Resident #12 had a [DIAGNOSES REDACTED].
a. The Plan of Care updated on [DATE] documented a problem of, Daily anticoagulant as per MD orders for CAD ([MEDICAL CONDITION]) with potential for easily bleeding and or bruising with interventions that included Administer meds as ordered, obtain and monitor/diagnostic work as ordered. Report results to MD and follow-up as ordered.
b. A physician's order dated [DATE] documented, Increase [MEDICATION NAME] to 10 mg daily for 7 days and Repeat PT/INR as scheduled.
c. Lab results dated [DATE] documented [MEDICATION NAME] 15.3 and INR 1.34. There was a hand written order on the form to increase [MEDICATION NAME] to 10.5 mg daily and repeat PT/INR in 7 days.
The [DATE] MAR indicated [REDACTED].
The MAR indicated [REDACTED].
d. On [DATE] at 2:00 p.m., the resident's medication from the cart was reviewed. There was only one card of [MEDICATION NAME] 10 mg in the cart.
On [DATE] at 11:25 a.m., the pharmacy tech stated that the [MEDICATION NAME] 0.5 mg was sent out on the 11th. She further stated that they send enough for 7 doses and then received information from the facility that it was discontinued on [DATE].
There was no documentation in the nurses notes or lab slips that the dose had been decreased to 10 mg. The MAR indicated [REDACTED].
e. The next PT/INR was drawn [DATE] instead of on the 17th as ordered.
5. The Immediate Jeopardy was removed , and the Scope/Severity was lowered to an H on [DATE] at 3:00 p.m., when the facility implemented the following plan of removal.
a. The Director of Nursing/Assistant Director of Nursing and RN (Registered Nurse) Treatment Nurse were inserviced on the protocol for PT/INR and the PT/INR deviation sheet by the Corporate Quality Improvement Coordinator on [DATE] at 11:00 a.m The inservice included verification by the nurse that the results of the PT/INR were confirmed before giving the medication and if the lab was out of parameters or there was no results then they are to contact the physician to determine medication order for [MEDICATION NAME] and other items noted.
b. Each of the five (5) residents medical records, who are on anticoagulation therapy were checked by Assistant Director of

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F 0333

Level of harm - Immediate jeopardy

Residents Affected - Some

(continued... from page 6)
Nursing and/or RN Treatment nurse on [DATE] from 2:30 p.m., to 4:00 p.m for correct orders, Electronic medical record and medication cart accuracy.
c. All residents receiving [MEDICATION NAME] were assessed on [DATE] from 11:15 a.m., to 2:26 p.m by the Assistant Director of Nursing and/or Registered Nurse treatment nurse with no abnormal findings.
d. The medication carts (3) were audited for correct [MEDICATION NAME] dosages for the five (5) residents on [DATE] by the Assistant Director of Nursing and/or RN Treatment Nurse
e. The PT/INR deviation sheet was put into use by the Assistant Director Of Nurses and/or RN Treatment nurse on [DATE] at 11:15 a.m All nursing working the current shift were inserviced on the PT/INR deviation sheet by the Assistant Director of Nurses and/or RN Treatment Nurse on [DATE] at 11:15 a.m The inservice included verification by the nurse that the results of the PT/INR were confirmed before giving the medication and if the lab was out of parameters or there was no results then they are to contact the physician to determine medication order for [MEDICATION NAME] and other items noted. All other licensed nurses will be inserviced by the Assistant Director of Nurses and/or RN Treatment Nurses before beginning his/her assigned shift and outgoing to include new employees and any employees returning from leave or absence.
f., The physician, Medical Director, was contacted on [DATE] at 11:30 a.m., by the Director of Nursing for all residents on anticoagulation therapy and an order was obtained to draw PT/INR. The lab company was contacted by the Director of Nursing and on [DATE] arrived in the facility to draw stat PT/INR's on all residents on anticoagulation therapy on [DATE] at 3:00 p.m
g. The pharmacy was notified by the Director of Nursing on [DATE] and arrived at 2:00 p.m., of issue and a consultant pharmacist conducted an audit of all medications to assure appropriate labs are being drawn for therapeutic medication levels
h. The Director of Nursing and/or Assistant Director of Nursing will audit all [MEDICATION NAME] orders dosages given and any labs associated with [MEDICATION NAME] for 3 months. The DON/ ADON will audit 5 x week for 3 months starting on [DATE].
Results from audit will be presented at the monthly QAPI meeting for further evaluation and any abnormal findings will immediately be corrected and reported to Administrator and Medical Director.

B. Based on observation, record review and interview, the facility failed to ensure residents were free from significant medication errors for 1 (Resident #15) of 2 (Residents #10 and #15) case mix residents who had orders for [MEDICATION NAME] R insulin and for 3 (Residents # 13, 21, and 22) of 3 case mix residents who had orders for [MEDICATION NAME]. These failed practices had the potential to cause more than minimal harm to 4 residents in the facility who had orders for [MEDICATION NAME] R insulin and 3 residents in the facility who had orders for [MEDICATION NAME] according to the lists provided by the Director of Nursing on [DATE]. The findings are:
1. Resident #15 had [DIAGNOSES REDACTED]. The Admission MDS with ARD dated [DATE] documented the resident was oriented to
person, place, time and situation and was verbally appropriate.
a. The [DATE] Medication Administration Record [REDACTED]. until [DATE] x 7 days then reassess. Start date [DATE].
b. The Order Summary Report for [DATE] documented, Insulin Regular Human Solution. Inject as per sliding scale: if ,[DATE] = 3 units; 200 - 249 = 5 units; 250 - 299 = 7 units; 300 - 349 = 9 units; 350 - 399 = 11 units. Notify provider for FSBS (Finger Stick Blood Sugar) less than 70 mg/dl and greater than 400 mg/dl, subcutaneously before meals and at bedtime for Diabetes Mellitus Insulin Regular [MEDICATION NAME] Solution.
c. On [DATE] at 8:20 a.m., Licensed Practical Nurse (LPN) #1 performed a finger stick blood sugar on Resident #15 with a result of 315. The physician's orders documented the resident would require 9 units of [MEDICATION NAME] R insulin. LPN #1 stated, I'm going to call the MD or Nurse Practitioner and let them know the resident is scheduled to get the blood sugars after the meal. The sliding scale insulin was not given to the resident. LPN #1 stated, I didn't have the insulin (the resident) needs in the building.
This was a significant error based on the classification of the drug.
2. Resident #13 had [DIAGNOSES REDACTED].
a. The Order Summary Report for [DATE] documented, [MEDICATION NAME] tablet 100 mg: Give 1.5 tablet by mouth at bedtime .
(start date [DATE]). [MEDICATION NAME] tablet 50 mg. Give 1 tablet by mouth one time a day . (start date [DATE]) CBC (complete blood count) with diff (differential) with absolute neuraphil (sic) count weekly x 6 months. Start Date [DATE].
b. The [DATE] MAR indicated [REDACTED]. The MAR indicated [REDACTED].
c. The [DATE] MAR indicated [REDACTED]. The MAR indicated [REDACTED].
d. The electronic medical record progress notes were reviewed on [DATE] and documented as follows:
[DATE] 21:52 (9:52 p.m.) WBC (White Blood Count) (with) Diff faxed to Central Pharmacy.
[DATE] 21:15 (9:15 p.m.) [MEDICATION NAME] (sic) not available.
[DATE] 9:06 a.m. Unavailable at this time.
[DATE] 9:07 a.m. Unavailable at this time.
e. On [DATE] a 1:53 p.m , the pharmacy provider representative, Pharmacist #1, stated that a 7 day supply of [MEDICATION NAME] was sent to the facility on [DATE] for Resident #13, and none had been sent since.
f. On [DATE] at 2:00 p.m., LPN #6 was asked for a copy of any [MEDICATION NAME] that Resident #13 had in the medication cart. LPN #6 provided a copy of an empty med card for [MEDICATION NAME] that was dispensed on [DATE] that contained 7 doses
of [MEDICATION NAME] 150 mg. LPN #6 was asked, If the [MEDICATION NAME] was delivered on [DATE], would the last dose be
given on [DATE]? LPN #6 stated, I suppose so. LPN #3 was asked, Is there [MEDICATION NAME] in the building for the resident? LPN #6 stated, No.
A total of 5 doses were not given between [DATE] and [DATE].
g. This was a significant error based on the frequency of the error.
3. Resident #22 had [DIAGNOSES REDACTED]. The Admission MDS with an ARD of [DATE] documented the resident scored 11 (,[DATE]
indicates moderately impaired) on the BIMS; had inattention and disorganized thinking that fluctuated, had no behaviors; and received antipsychotic, antianxiety, antidepressant and hypnotic drugs daily.
a. The Plan of Care created on [DATE] documented, Focus: (Name of Resident) has a potential for adverse side effects d/t (due to) daily use of antipsychotic as per MD orders for her DX (diagnosis) of [MEDICAL CONDITION] and [MEDICAL CONDITION]
Disorder; . Interventions: Administer anti-psychotic as per MD order monitoring and observing for adverse side effects, notifying MD as indicated.
b. The Order Summary Report for [DATE] documented, [MEDICATION NAME] tablet: Give 150 mg by mouth at bedtime . (Start date
[DATE]) . [MEDICATION NAME] tablet: Give 50 mg by mouth in the morning . (Start date [DATE]) .
c. The [DATE] MAR indicated [REDACTED].
d. The [DATE] Medication Administration Record [REDACTED].
e. The electronic medical record progress notes documented as follows:
[DATE] 6:25 a.m. Refused AM (morning) meds.
[DATE] 20:01 (8:01 p.m.) Blood drawn - have not received med. (medication) from pharmacy.
[DATE] 00:58 (a.m.) . Resident up in w/c (wheelchair) in DR (dining room) at this time. Talking to people that are not there. Also making loud animal sounds and screaming at herself.
[DATE] 21:13 (9:13 p.m.) [MEDICATION NAME] (sic) not available.
[DATE] 05:49 (a.m.) [MEDICATION NAME] (sic) not available.
[DATE] 05:53 (a.m.) Not available.
f. On [DATE] at 1:53 p.m., a pharmacy representative, Pharmacist #1, from the company that supplied the facility with medication was interviewed via the telephone. Pharmacist #1 stated that a 7 day supply of the morning and bedtime dose of [MEDICATION NAME] was sent to the facility on [DATE] and on [DATE]. The 7 day supply sent on [DATE] would have been depleted on [DATE].
There was no [MEDICATION NAME] in the facility to administer to the resident from [DATE] until the medication was sent on [DATE]. On [DATE], the [DATE] MAR indicated [REDACTED]. A total of 10 doses (5 morning and 5 bedtime) of [MEDICATION NAME]
were not administered to the resident.
This was significant based on the frequency of the error.
3. Resident #21 had [DIAGNOSES REDACTED].
a. The [DATE] Order Summary Report documented, [MEDICATION NAME] Tablet 100 mg 3.5 tablets by mouth at bedtime . CBC Q week

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	045314	A. BUILDING _____ B. WING _____	08/28/2015

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
RED OAK HEALTHCARE AND REHAB, LLC	1010 BARNES STREET LONOKE, AR 72086

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 0333 **Level of harm** - Immediate jeopardy **Residents Affected** - Some	(continued... from page 7) every day shift every Mon (Monday) for [MEDICATION NAME] Refill. b. The Plan of Care revised on [DATE] documented, Focus: (Name of Resident) has a potential for adverse side effects d/t daily use of antipsychotic as per MD orders for his dx of [MEDICAL CONDITION]. Interventions: Administer antipsychotic medication as ordered by physician. Monitor for side effects and effectiveness . c. The [DATE] MAR indicated [REDACTED]. d. The electronic medical record progress notes were reviewed and documented as follows: [DATE] 19:57 (7:57 p.m.) Unable to administer. [MEDICATION NAME] (sic) not available. [DATE] 20:11 (8:11 p.m.) Gamma Lab here to venipuncture resident for CBC. [DATE] 23:57 (11:57 p.m.) Received results of CBC/diff and was faxed to (Name of pharmacy). [DATE] 20:06 (8:06 p.m.) Blood drawn - haven't received med from pharm (pharmacy). [DATE] 21:11 (9:11 p.m.) Scheduled lab not drawn nor scheduled [MEDICATION NAME] not available at this time. e. On [DATE] at 1:53 p.m., a pharmacy representative, Pharmacist #1, from the company that supplied the facility with medication was interviewed via the telephone. Pharmacist #1 stated that a 7 day supply of [MEDICATION NAME] was sent to the facility on [DATE] and on [DATE]. The 7 day supply sent on [DATE] would have been depleted on [DATE]. A total of 7 doses of [MEDICATION NAME] 100 mg 3.5 tablets at bedtime were not administered to the resident between [DATE] and [DATE]. f. This was significant based on the frequency of the error.
F 0363 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Make sure menus meet the resident's nutritional needs and that there is a prepared menu by which nutritious meals have been planned for the resident and followed.** br>Complaint # (AR 563) and Complaint # (AR 590) were substantiated, all or in part, in these findings. Based on observation, record review and interview, the facility failed to ensure meals were prepared and served according to the planned, written menu to meet the nutritional needs of the residents for 1 of 1 meals observed. The failed practice had the potential to affect 24 residents who received regular diets and 14 residents who received mechanical soft diets according to the diet list provided by the facility on 8/24/15. The findings are: 1. The facility's menu for the 8/23/15 supper meal documented for regular and mechanical soft diets to receive 1/2 cup of soup of choice. 2. On 8/23/15 at 4:45 p.m., there was no soup prepared for the residents on regular or mechanical soft diets. At 5:30 p.m., 24 out of 26 residents on regular diet and 14 residents on mechanical diet were not offered soup. 3. On 8/23/15 at 5:47 p.m. Dietary Employee #4 was asked if soup was prepared for supper. She stated, We do not have enough cans of soup to make soup. We only have one can of cream of mushroom and one can of cream of chicken soup. They are the only cans of soup that we have. 4. On 8/23/15 at 5:48 p.m., Dietary Employee #3 was asked if soup was prepared for supper. He stated, I gave 2 residents cream of mushroom soup. We did not have soup for tonight. 5. On 8/24/15 at 12:07 a.m., Resident #12, who was on regular diet with no concentrated sweets/double portions was asked if the facility had run out of food. He stated, They had run out of food about 3 weekends ago. They had somebody from the kitchen go and get something from the grocery store, such as eggs, watermelon, grapes and cantaloupe to serve for breakfast. For dinner, they went and got mixed vegetables and beets. I never got enough to eat since I have been here. They said they put enough on my plate, but I never get full. I get double portions of food. I didn't get soup last night.
F 0371 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Store, cook, and serve food in a safe and clean way** br>Complaint # (AR 585) was substantiated, all or in part, in these findings. Based on observation and interview, the facility failed to ensure the ice machine was operational to produce enough ice to meet the residents' needs. The failed practice had the potential to affect 55 residents who received their meal trays from the kitchen as identified from the diet list provided by the facility. (Total Census 61) The findings are. 1. On 8/23/13 at 1:18 p.m., the ice machine in the kitchen had less than 1 cubic foot of ice in it. The ice machine panel, inside back of the ice machine where ice piled up and the corners of the ice machine had accumulation of reddish, grayish residue. Dietary Employee #2 stated, The ice machine works, but it dumps slow and stated, What was in the ice machine will not be enough for one hall. She also stated, We clean it every two weeks. 2. On 8/23/15 at 2:43 p.m., the Administrator stated that the ice machine has been out for 3 weeks. The Administrator stated, I am getting new machine. I have been buying ice since then. 3. On 8/23/15 at 3:44 p.m. Dietary Employee #1 stated, The ice machine works, but it does not drop enough ice for us to give to the residents or use when giving beverages. When we don't have ice, we fill the glasses with water and put them in the refrigerator to keep them cold before the meal. This has been going on since 3 months. On 8/23/15 at 4:02 p.m. Dietary Employee #3 stated, The ice machine makes only a little ice. We do not have enough to give to the residents. We do not have enough to put in their drinks. We just put their drinks in the refrigerator to chill.
F 0425 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Safely provide drugs and other similar products available, which are needed every day and in emergencies, by a licensed pharmacist** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Complaint # (AR 585) was substantiated, all or in part, in these findings. Based on observation, record review and interview, the facility failed to ensure timely identification and removal from current medication supply of narcotic medications for final disposition for 3 of 4 medication carts (West, South and Central) for 7 (Residents #29-35) case mix residents. The facility failed to ensure that Clozapine was provided for 3 (Residents #13, #21, and #22) case mix residents who had orders for Clozapine. The facility failed to ensure Valium 5 mg (milligrams) was available in the facility to administer when needed to 1 (Resident #4) of 1 case mix resident had an order for [REDACTED]. The findings are: 1. On 8/23/15 at 5:00 p.m., Licensed Practical Nurse (LPN) #3 was asked to see any drugs in the narcotic box on the West Hall medication cart for any residents discharged from the facility. The following was observed: a. A medication card belonging to Resident #29 (dispensed on 2/16/15) was still in the narcotic box and contained 11 Lorazepam 0.5 mg tablets. The discharge list provided by the Administrator on 8/26/15 documented the resident was discharged on [DATE]. b. A medication card belonging to Resident #30 (dispensed on 5/13/15) was still in the narcotic box and contained 27 Diazepam 5 mg tablets. The discharge list provided by the Administrator documented the resident was discharged on [DATE]. c. A medication card belonging to Resident #30 (dispensed on 5/13/15) was still in the narcotic box and contained 53 Oxycodone 30 mg tablets. The discharge list provided by the Administrator documented the resident was discharged on [DATE]. d. A medication card belonging to Resident #30 (dispensed on 5/13/15) was still in the narcotic box and contained 27 Methadone HCL 5 mg tablets. The discharge list provided by the Administrator documented the resident was discharged on [DATE]. e. On 8/23/15 at 5:00 p.m., LPN #3 was asked, How long do narcotics stay in the cart after the resident is discharged ? LPN #3 stated, I don't know. At 5:05 p.m., LPN #3 was asked, Who is supposed to clean out the cart? LPN #3 stated, The DON (Director of Nursing). 2. On 8/23/15 at 5:10 p.m., LPN #4 was asked to see any drugs in the narcotic box on the South Hall medication cart for any residents who were discharged from the facility. The following was observed: a. A medication card belonging to Resident #31 (dispensed on 5/11/15) was still in the narcotic box and contained 25 half tablets of Methadone HCL 5 mg tablets (2.5 mg). The discharge list provided by the Administrator documented the resident was transferred to another facility on 8/17/15. The May 2015 Medication Administration Record [REDACTED]. b. A medication card belonging to Resident #32 (dispensed on 6/10/15) was still in the narcotic box and contained 16 Temazepam 30 mg tablets. The discharge list provided by the Administrator documented the resident was discharged to the

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F 0425 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 8) hospital on [DATE]. c. A medication card belonging to Resident #33 (dispensed on 7/16/2014) was still in the narcotic box and contained 30 Lorazepam 0.5 mg tablets. The discharge list provided by the Administrator documented the resident was discharged to the hospital on [DATE]. The expiration date on the medication card was 7/16/15. 3. On 8/23/15 at 5:18 p.m., LPN #5 was asked to see any drugs in the narcotic box on the South Hall medication cart for any residents who were discharged from the facility. The following was observed: a. A medication card belonging to Resident #34 (dispensed on 4/3/15) was still in the narcotic box and contained 60 Hydrocodone/Acetaminophen 10-325 tablets. The discharge list provided by the Administrator documented the resident was discharged to the hospital on [DATE]. b. A medication card belonging to Resident #35 (dispensed on 5/5/15) was still in the narcotic box and contained 23 half tablets of Hydromorphone HCL 2 mg tablets. The discharge list provided by the Administrator documented the resident was discharged to the hospital on [DATE]. c. A medication card belonging to Resident #35 (dispensed on 6/9/15) was still in the narcotic box and contained 29 Hydrocodone/Acetaminophen 7.5-325 tablets. The discharge list provided by the Administrator documented the resident was discharged to the hospital on [DATE]. 4. On 8/23/15 at 6:00 p.m., the DON was asked, When was the last time the drugs have been logged (removed from cart)? The DON stated, What I was told to do is wait until the sheet got filled up, and it's not filled up. 5. Resident #13 had [DIAGNOSES REDACTED]. a. The Order Summary Report for August 2015 documented, Clozapine tablet 100 mg: Give 1.5 tablet by mouth at bedtime . (start date 1/22/2015). Clozapine tablet 50 mg. Give 1 tablet by mouth one time a day . (start date 1/23/2015). b. The August 2015 MAR indicated [REDACTED]. The MAR indicated [REDACTED]. c. The August 2015 MAR indicated [REDACTED]. The MAR indicated [REDACTED]. d. The electronic medical record progress notes were reviewed on 8/26/15 and documented as follows: 8/15/15 21:52 (9:52 p.m.) WBC (White Blood Count) (with) Diff (differential) faxed to Central Pharmacy. 8/21/15 21:15 (9:15 p.m.) Clozapine (sic) not available. 8/25/15 9:06 a.m. Unavailable at this time. 8/25/15 9:07 a.m. Unavailable at this time. There was no documentation the physician was notified the Clozapine was not being administered. e. On 8/26/15 a 1:53 p.m., the pharmacy provider representative, Pharmacist #1, stated that a 7 day supply of Clozapine was sent to the facility on [DATE] for Resident #13, and none had been sent since. f. On 8/26/15 at 2:00 p.m., LPN #6 was asked for a copy of any Clozapine that Resident #13 had in the medication cart. LPN #6 provided a copy of an empty med card for Clozapine that was dispensed on 8/17/15 that contained 7 doses of Clozapine 150 mg. LPN #6 was asked, If the Clozapine was delivered on 8/17/15, would the last dose be given on 8/23/15? LPN #6 stated, I suppose so. LPN #3 was asked, Is there Clozapine in the building for the resident? LPN #6 stated, No. 6. Resident #22 had [DIAGNOSES REDACTED]. The Admission MDS with an ARD of 6/11/15 documented the resident scored 11 (8-12 indicates moderately impaired) on the BIMS; had inattention and disorganized thinking that fluctuated; had no behaviors; and received antipsychotic, antianxiety, antidepressant, and hypnotic drugs daily. a. The Plan of Care created on 6/16/15 documented, Focus: (Name of Resident) has a potential for adverse side effects d/t (due to) daily use of antipsychotic as per MD orders for her DX (diagnosis) of Schizophrenia and Bipolar Disorder; . Interventions: Administer antipsychotic as per MD order monitoring and observing for adverse side effects, notifying MD as indicated . b. The Order Summary Report for August 2015 documented, Clozapine tablet: Give 150 mg by mouth at bedtime . (Start date 6/4/2015) . Clozapine tablet: Give 50 mg by mouth in the morning . (Start date 6/4/2015) . c. The August 2015 MAR indicated [REDACTED]. d. The August 2015 MAR indicated [REDACTED]. e. The electronic medical record progress notes documented as follows: 8/10/15 6:25 a.m. Refused AM (morning) meds. 8/11/15 20:01 (8:01 p.m.) Blood drawn - have not received med. (medication) from pharmacy. 8/21/15 00:58 (a.m.) . Resident up in w/c (wheelchair) in DR (dining room) at this time. Talking to people that are not there. Also making loud animal sounds and screaming at herself. 8/21/15 21:13 (9:13 p.m.) Clozapine (sic) not available. 8/22/15 05:49 (a.m.) Clozapine (sic) not available. 8/23/15 05:53 (a.m.) Not available. There was no documentation the physician was notified that the medication was not being administered to the resident. f. On 8/26/15 at 1:53 p.m., a pharmacy representative, Pharmacist #1, from the company that supplied the facility with medication stated that a 7 day supply of the morning and bedtime dose of Clozapine was sent to the facility on [DATE] and 8/24/15. The 7 day supply sent on 8/11/15 would have been depleted on 8/19/15. There was no Clozapine in the facility to administer to the resident from 8/20/15 until the medication was sent on 8/24/15. On 8/24/15, the August 2015 MAR indicated [REDACTED]. A total of 10 doses (5 morning and 5 bedtime) of Clozapine were not administered to the resident. 7. Resident #21 had [DIAGNOSES REDACTED]. a. The August 2015 Order Summary Report documented, Clozapine Tablet 100 mg 3.5 tablets by mouth at bedtime . b. The Plan of Care revised on 6/29/15 documented, Focus: (Name of Resident) has a potential for adverse side effects d/t daily use of antipsychotic as per MD orders for his dx of schizophrenia. Interventions: Administer antipsychotic medication as ordered by physician. Monitor for side effects and effectiveness . c. The August 2015 MAR indicated [REDACTED]. d. The electronic medical record progress notes were reviewed and documented as follows: 8/1/15 19:57 (7:57 p.m.) Unable to administer. Clozapine (sic) not available. 8/2/2015 20:11 (8:11 p.m.) Gamma Lab here to venipuncture resident for CBC (complete blood count). 8/2/2015 23:57 (11:57 p.m.) Received results of CBC/diff and was faxed to (Name of pharmacy). 8/11/15 20:06 (8:06 p.m.) Blood drawn - haven't received med from pharm (pharmacy). 8/21/15 21:11 (9:11 p.m.) Scheduled lab not drawn nor scheduled Clozapine not available at this time. There was no documentation the physician was notified that the Clozapine was not being administered. e. On 8/26/15 at 1:53 p.m., a pharmacy representative, Pharmacist #1, from the company that supplied the facility with medication stated that a 7 day supply of Clozapine was sent to the facility on [DATE] and 8/24/15. The 7 day supply sent on 8/11/15 would have been depleted on 8/18/15. A total of 7 doses of Clozapine 100 mg 3.5 tablets at bedtime were not administered to the resident between August 1 and August 24, 2015. 8. Resident #4 had [DIAGNOSES REDACTED]. The Admission MDS with an ARD of 6/24/15 documented the resident scored 15 (13-15 indicates cognitively intact) on the BIMS, had no behaviors, and experienced constant pain. a. The Medication Review Report for August 2015 documented, Valium Tablet 5 mg . Give 1 tablet by mouth every 12 hours as needed for severe muscle spasm. (start date 6/17/2015). b. The Plan of Care revised on 7/3/2015 documented, Focus: (Name of Resident) has an alteration in his ADL functions s/p (status [REDACTED]. Interventions: Generic drugs may be used unless physician specifies. Medication as per MD orders. Focus: (Name of Resident) has an alteration in his comfort level d/t presence of pain rated at its worst at 10 out of 10 to his lower back . Interventions: Medications as ordered. c. The July 2015 and August 2015 MAR indicated [REDACTED]. d. On 8/26/15 at 8:45 a.m., Registered Nurse (RN) #1 was asked to see the medication card for the Valium 5 mg for Resident #4. RN #1 looked in the medication cart and could not find any card. RN #1 was asked, Is there a card for Valium 5 mg in the cart for (Resident #4)? RN #1 stated, No. e. On 8/26/15 at 1:53 p.m., Pharmacist #1 was asked if there had been any Valium 5mg dispensed from the pharmacy for Resident #4. Pharmacist #1 stated that no Valium 5mg had been dispensed and the drug had not been entered into the pharmacy's computer system.

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F 0425 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 9) f. On 8/28/15 at 9:15 a.m., the DON was asked, Why was it (the Valium) never obtained? The DON stated, I'm waiting on a call from the pharmacy. I don't know why. 9. On 8/26/15 at 1:10 p.m., the DON was asked, Who is your pharmacy consultant? The DON stated, We will have Pharmacy #2 on September 1st. The DON was asked, Is there no pharmacy consultant (now)? The DON stated, Pharmacy #1 saw the residents this month. The DON was asked, What is the problem with Pharmacy #1 providing meds (medications)? The DON stated, They haven't been paid. 10. Laws and Regulations, Arkansas State Board of Pharmacy, published July 2015 documented, Regulation 5 - Long Term Care Facilities . 05-00-003 Responsibilities . (b) Control and accountability of all legend drugs (including controlled substance) (3) The consultant pharmacist(s) shall establish procedures to insure that: (D) Controlled drugs. All discontinued and outdated controlled drugs shall be signed out of narcotic inventory at the time of discontinuation or at the point of being outdated and shall be entered on the Arkansas Department of Health ' s Report of Drugs Surrendered form by a designated nurse and the director of nurses. Said outdated or discontinued drugs shall be secured in the office of the director of nurses pursuant to paragraph 3(A) of this section until sent to the Department of Health. The consultant pharmacist shall confirm the quantity of drugs segregated for shipment to the Arkansas Department of Health is accurately entered on the inventory of controlled substances recorded on the Report of Drugs Surrendered form. 11. The CFR (Code of Federal Regulations) 21 §1317.80 documented, Collection receptacles at long-term care facilities. (a) A long-term care facility may dispose of controlled substances in Schedules II, III, IV, and V on behalf of an ultimate user who resides, or has resided, at such long-term care facility by transferring those controlled substances into an authorized collection receptacle located at that long-term care facility. When disposing of such controlled substances by transferring those substances into a collection receptacle, such disposal shall occur immediately, but no longer than three business days after the discontinuation of use by the ultimate user. Discontinuation of use includes a permanent discontinuation of use as directed by the prescriber, as a result of the resident's transfer from the long-term care facility, or as a result of death.
F 0441 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Have a program that investigates, controls and keeps infection from spreading.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to ensure medications were passed to residents in a manner to minimize the potential for cross contamination and spread of infection for 3 (Residents #18, #23, and #4) of 14 residents observed during the medication pass. This failed practice had the potential to affect 20 residents on the South Hall and 11 residents on the West hall who received medications from the nurses according to the census sheets provided by the Director of Nursing on 8/28/15. The findings are: 1. Resident #18 had [DIAGNOSES REDACTED]. The August 2015 Medication Summary documented, [MEDICATION NAME] Chewable ([MEDICATION NAME]) give 100 mg (milligrams) by mouth two times a day. On 8/24/15 at 9:15 a.m., Registered Nurse (RN) #1 dropped an ink pen in the floor, picked up the pen from the floor, and without washing hands, opened a capsule of [MEDICATION NAME] Sodium and placed the contents into a 30 cc (cubic centimeter) med (medication) cup and crushed the [MEDICATION NAME] with the other medications being administered. RN #1 was asked, You dropped your pen in the floor, picked it up, then used your bare hands to open the [MEDICATION NAME] capsule. Is there a reason you didn't wash your hands prior to handling the medicine? RN #1 stated, No. 2. Resident #23 had [DIAGNOSES REDACTED]. The August 2015 Medication Order Summary documented, [MEDICATION NAME] Diskus Aerosol Powder Breath Activated 250-50 mcg (micrograms)/Dose . 1 puff inhale two times a day . On 8/24/15 at 3:48 p.m., Licensed Practical Nurse (LPN) #2 was at the medication cart in the South Hallway. The LPN had set up the medications for Resident #23 in a cup. LPN #2 picked up the medication cup and the [MEDICATION NAME] Diskus round container and walked from the med cart toward the resident's room. LPN #2 dropped the [MEDICATION NAME] Diskus on the floor in the hallway. LPN #2 picked up the [MEDICATION NAME] Diskus and carried it to the resident, and without washing it off or washing his hands, administered the medication to the resident. LPN #2 was asked, What are you supposed to do if you drop an inhaler in the floor? LPN #2 stated, I don't know. LPN #2 was asked, When something has been in the floor is it clean? LPN #2 stated, No, it's dirty. 3. Resident #4 had [DIAGNOSES REDACTED]. The August 2015 Order Summary Sheet documented, [MEDICATION NAME] Sodium Capsule 100 mg . two times a day . Multivitamin Capsule . Give 1 capsule by mouth one time a day for supplement. On 8/25/15 at 8:25 a.m., RN #1 took a bottle of [MEDICATION NAME] Sodium 100 mg from the med cart, poured one of the pills into her bare hand, then placed the medicine in a medicine cup. RN #1 then took the stock medicine bottle containing multivitamins and poured 3 tablets into the medicine cup on top of the [MEDICATION NAME] that had been in the nurse's bare hand. RN #1 then poured the excess 2 multivitamin tablets back into the stock multivitamin bottle, contaminating the bottle. RN #1 was asked, Is there a reason you poured that ([MEDICATION NAME] sodium) into your hand? RN #1 stated, No.

F 0490 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	**Be administered in an acceptable way that maintains the well-being of each resident .** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Complaint # (AR 590) and Complaint # (AR 585) were substantiated, all or in part, in these findings. Based on observation, record review and interview, the facility failed to ensure funds were promptly provided to allow for effective facility administration to maintain Lab Services to ensure high risk medications ([MEDICATION NAME]) were monitored for potential toxic levels for 3 of 3 (Residents #17, #11 and #12) case mix residents who received anticoagulant therapy. The failed practice resulted in Immediate Jeopardy which caused or could have caused serious harm, injury or death to 1 (Resident #17) who expired [DATE] with a critically high INR and 2 (Residents #11 and #12) who had orders for [MEDICATION NAME] and no consistent PT/INR ([MEDICATION NAME] Time/International Normalized Ratio) monitoring. The failed practice had the potential to cause more than minimal harm 5 residents who received anticoagulation therapy. The facility was notified of the Immediate Jeopardy on [DATE] at 9:53 a.m. The facility also failed to ensure that laboratory work was performed to monitor for potentially harmful blood dyscrasias and to ensure pharmacy could continue to send the medication for 3 of 3 (Resident #13, #21, and #22) case mix residents who had orders for [MEDICATION NAME]. This failed practice had the potential to cause more than minimal harm for 3 residents in the facility who had orders for [MEDICATION NAME] according to the list provided by the Director of Nursing (DON) on [DATE]. The findings are: 1. On [DATE] at 4:00 p.m., the DON stated the previous lab company had notified her on [DATE] that they would no longer draw lab because they had not been paid. She stated that she called the corporate office and they told her, You are there, you handle it. She stated that she notified the local hospitals and they would not do it. She stated that she them called the Health Department and they told her that she would need more training. She stated that she found a business card for the lab services that are now contracted with the facility. On [DATE] at 4:17 p.m., a representative from the lab that refused to draw anymore lab since [DATE] was interviewed. This person stated that the reason they stopped was because they had not received any payment since 2013. 2. On [DATE] at 1:10 p.m., the DON was asked, Who is your pharmacy consultant? The DON stated, We will have Pharmacy #2 on [DATE]st. The DON was asked, Is there no pharmacy consultant (now)? The DON stated, Pharmacy #1 saw the residents this month. The DON was asked, What is the problem with Pharmacy #1 providing meds (medications)? The DON stated, They haven't been paid. 3. According to the Nursing 2015 Drug Handbook, [MEDICATION NAME] is a Anticoagulants. For Administration of oral [MEDICATION NAME] PT/INR determinations are essential for proper control. The black Box warning documented [MEDICATION NAME] can cause major or fatal bleeding. Regularly monitor INR in all patients. 4. Resident #17 had [DIAGNOSES REDACTED]. The Significant Change Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of [DATE] documented the resident scored 15 (,[DATE] indicates cognitively intact) on the Brief Interview for Mental Status (BIMS); was independent with activities of daily living, and received anticoagulant therapy 2 days of the past 7 days. a. A physician's order dated [DATE] documented, [MEDICATION NAME] Sodium 6 mg (milligrams) give 1 tablet by mouth one time a day for [MEDICAL CONDITION] give with 7.5 mg tab = (equals) 13.5 mg. Another physician's order dated [DATE] documented,

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	045314	A. BUILDING _____ B. WING _____	**08/28/2015**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
RED OAK HEALTHCARE AND REHAB, LLC	**1010 BARNES STREET LONOKE, AR 72086**

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 0490

Level of harm - Immediate jeopardy

Residents Affected - Some

(continued... from page 10)
[MEDICATION NAME] Sodium tablet 7.5 mg give 1 tablet one time a day for [MEDICAL CONDITION]. Give with 6 mg to = 13.5 mg.
b. The temporary plan of care for the resident dated [DATE] did not address the Anticoagulant therapy or the risk factors associated with anticoagulant therapy.
c. The [DATE] Medication Administration Record [REDACTED]. The MAR indicated [REDACTED]. The MAR indicated [REDACTED]. One time only for therapeutic levels for 1 day. This was administered one time on [DATE]. However, there was no physician order in the clinical record to do this.
d. The [DATE] MAR indicated [REDACTED]. The June MAR indicated [REDACTED].
e. A PT/INR results dated [DATE] documented the [MEDICATION NAME] as 49 (10XXX,[DATE].1 normal range) and the INR as 4.45 (0XXX,[DATE].2 normal range). The physician wrote on the lab sheet to hold ([MEDICATION NAME]) and repeat (PT/INR) in 3 days.
f. The PT/INR results dated [DATE] was [MEDICATION NAME] 15.8 and the INR as 1.39. The physician wrote on the lab slip to increase to 11 mg for one week and then repeat the INR. (The [DATE] MAR indicated [REDACTED]
A physician's telephone order dated [DATE] documented [MEDICATION NAME] 11 mg po (oral) x (times) 1 week and repeat PT/INR as scheduled. The [DATE] MAR indicated [REDACTED].
g. The next PT/INR's were drawn on [DATE], [DATE] and [DATE] and the physician initialed the lab slips.
A telephone order that was not dated documented, Increase [MEDICATION NAME] 10.5 mg x one week and repeat PT/INR x 7 days.
h. Nurses notes dated [DATE] at 7:53 p.m., documented, Lab results called to on call APN (Advanced Practice Nurse) at 12:40 p.m No N.O. (new orders) received at this time. Resident later observed to be lethargic VS (vital signs) 100.3, 85, 20 ,[DATE], pulse ox 70 to 93% on O2 (oxygen). Order received to TF (transfer) to hospital. EMS (Emergency Medical Services) notified of transfer at 1:56 a.m.
i. On [DATE] the resident was readmitted to the facility with orders for [MEDICATION NAME] 7.5 mg give 2 tablets to = 15 mg and [MEDICATION NAME] 06 mg/0.6Ml (milliliter) - give 0.6 ml SQ (subcutaneous) daily. PT/INR daily until INR is between 2.0 -3.0, then once therapeutic level reached D/C (discontinue) [MEDICATION NAME].
The [DATE] MAR indicated [REDACTED]. The August MAR indicated [REDACTED]. However, the pharmacy stated that they sent out 7 doses on [DATE].
j. The next PT/INR dated [DATE] documented INR of 1.85. The physician hand wrote an order Increase to 15.5 mg daily x 7 days and repeat PT/INR.
The August [DATE] documented the resident received 15 mg of [MEDICATION NAME] instead of 15.5 mg from [DATE] - [DATE], [DATE], and [DATE] - [DATE] at 5 p.m. (held on [DATE], [DATE], and [DATE]). The MAR indicated [REDACTED].
k. The next PT/INR was drawn on [DATE] and the INR was documented as 1.94.
A physician's order dated [DATE] to documented, D/C (discontinue) [MEDICATION NAME] R/T (related to) INR 2.3. (INR results was 1.94 not 2.3)
l. The PT/INR results dated [DATE] documented the INR at 3.16. The PT/INR results dated [DATE] documented the INR as 4.04. There was no documentation on the lab sheet or the nurses notes that the physician or APN was notified of these results. A physician's order dated [DATE] at 10:06 a.m. documented to hold [MEDICATION NAME] for 2 days. Note: The [DATE] MAR indicated [REDACTED].
m. Nurses notes dated [DATE] documented, At 4:55 p.m., call placed to on-call APN and report given of concern about [MEDICATION NAME] dose with last INR greater that 4.0 (the one done on [DATE]). Received order to send R (resident) to ER (emergency room) for PT/INR lab draw. Order noted DON (Director of Nursing) and Administrator notified of TF (transfer) order. R (Resident) informed order to TF to ER (emergency room) for lab draw, and the need to find out where the current INR was before resuming dose. R made informed decision to refuse TF for lab draw. At 5:09 p.m., APN informed of R's refusal to TF out for lab. Received order to hold [MEDICATION NAME] until lab draw results received tomorrow. FU (follow-up) with on-call. Note: The [DATE] MAR indicated [REDACTED].
n. Nurses notes dated [DATE] at 6:55 p.m., documented, CNA (Certified Nursing Assistant) reported R was not breathing. Observed R in bed, w/o (with-out) respiration or pulse. Code Blue room [ROOM NUMBER] east paged over intercom. Call placed to (local ambulance service) report given this is (name of LPN) at (name of facility) (address of facility), I have a code blue situation in room [ROOM NUMBER] east. It is a bariatric patient send assistance. CPR initiated, EMS arrived, report given R TF to stretcher per staff and EMS. R out of building at 7:13 p.m. (name of family member) notified of TR at 7:15 p.m. Report called to (initials of hospital), Dr (name) notified of pronouncement at 8:19 p.m APN notified at 8:20 p.m.
o. A lab results collected on [DATE] at 1:10 p.m. documented INR of 6.02 High and [MEDICATION NAME] 53.4 High. This form documented, Results successfully called to (initials of lab contracted by the facility) at 8:21 p.m
On [DATE] at 4:00 p.m., the Director of Nurses stated that she called the lab and they told her that the reason the facility was not notified of the High INR was that they had no telephone number or anyway to contact the facility.
5. Resident #11 had a [DIAGNOSES REDACTED]. The Annual MDS with ARD of [DATE] documented the resident scored of 6 (,[DATE] indicates severe impairment) on the BIMS, required limited assistance with bed mobility and extensive assistance with dressing, was independent with the remainder of activities of daily living, and received an anticoagulant 7 days in the past 7 days.
a. The Plan of Care developed [DATE] documented a problem of, The resident is on anticoagulant Therapy [MEDICATION NAME] with interventions that included Administer Anticoagulant medications as ordered by the physician and Labs as ordered. Report abnormal lab results to MD.
b. A physician's order dated [DATE] documented, [MEDICATION NAME] 4 mg daily x 1 week. Repeat PT/INR as scheduled.
c. A lab report dated [DATE] documented the PT as 17.8 and the INR as 1.57. There was a physician's order dated [DATE] to increase the [MEDICATION NAME] to 5 mg daily and continue weekly PT/INR. The [DATE] MAR indicated [REDACTED].
d. A physician's order dated [DATE] documented, Increase [MEDICATION NAME] to 5.5 mg daily and repeat PT/INR in 7 days.
e. The next PT/INR was drawn on [DATE] (5 days later than when ordered).
f. The lab results dated [DATE] documented the [MEDICATION NAME] was 40.3 and the INR was 3.64. There was a hand written order on the lab slip that documented, Hold PT/INR ([MEDICATION NAME]? not clarified by facility) x 2 days and repeat PT/INR. The [DATE] MAR indicated [REDACTED].
g. A physician's order dated [DATE] documented, D/C (discontinue) [MEDICATION NAME] 5.5 mg and start [MEDICATION NAME] 4 mg one po at 5:00 p.m. and redraw PT/INR on [DATE].
h. The next PT/INR was drawn on [DATE], four days later than ordered.
6. Resident #12 had a [DIAGNOSES REDACTED].
a. The Plan of Care updated on [DATE] documented a problem of, Daily anticoagulant as per MD orders for CAD ([MEDICAL CONDITION]) with potential for easily bleeding and or bruising with interventions that included Administer meds as ordered, obtain and monitor/diagnostic work as ordered. Report results to MD and follow-up as ordered.
b. A physician's order dated [DATE] documented, Increase [MEDICATION NAME] to 10 mg daily for 7 days and Repeat PT/INR as scheduled.
c. Lab results dated [DATE] documented [MEDICATION NAME] 15.3 and INR 1.34. There was a hand written order on the form to increase [MEDICATION NAME] to 10.5 mg daily and repeat PT/INR in 7 days.
The [DATE] MAR indicated [REDACTED].
The MAR indicated [REDACTED].
d. On [DATE] at 2:00 p.m., the resident's medication from the cart was reviewed. There was only one card of [MEDICATION NAME] 10 mg in the cart.
On [DATE] at 11:25 a.m., the pharmacy tech stated that the [MEDICATION NAME] 0.5 mg was sent out on the 11th. She further stated that they send enough for 7 doses and then received information from the facility that it was discontinued on [DATE].
There was no documentation in the nurses notes or lab slips that the dose had been decreased to 10 mg. The MAR indicated [REDACTED].
e. The next PT/INR was drawn [DATE] instead of on the 17th as ordered.
7. Resident #13 had [DIAGNOSES REDACTED].
a. The Order Summary Report for [DATE] documented, [MEDICATION NAME] tablet 100 mg: Give 1.5 tablet by mouth at bedtime .
(start date [DATE]). [MEDICATION NAME] tablet 50 mg. Give 1 tablet by mouth one time a day . (start date [DATE]) . CBC (complete blood count) with diff (differential) with absolute neuraphil (sic) count weekly x 6 months. Start Date [DATE].

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F 0490 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 11) b. The clinical record had copies of lab results for a CBC with Diff that was performed on [DATE], [DATE], [DATE] and [DATE]. There were no results in the record for any CBC with Diff after [DATE] order would not have been discontinued until [DATE]. c. The [DATE] MAR indicated [REDACTED]. The MAR indicated [REDACTED]. d. The [DATE] MAR indicated [REDACTED]. The MAR indicated [REDACTED]. e. The electronic medical record progress notes were reviewed on [DATE] and documented as follows: [DATE] 21:52 (9:52 p.m.) WBC (White Blood Count) (with) Diff (differential) faxed to Central Pharmacy. [DATE] 21:15 (9:15 p.m.) [MEDICATION NAME] (sic) not available. [DATE] 9:06 a.m. Unavailable at this time. [DATE] 9:07 a.m. Unavailable at this time. f. On [DATE] at 8:45 a.m., Registered Nurse (RN) #1 was asked, Why are there skips in the [MEDICATION NAME] (administration)? RN #1 stated, I'm not sure why. [MEDICATION NAME] is an antipsychotic and needs a CBC. Copies of the CBC with diff performed since [DATE] were requested but not provided by the time of exit. 8. Resident #22 had [DIAGNOSES REDACTED]. The Admission MDS with an ARD of [DATE] documented the resident scored 11 (,[DATE] indicates moderately impaired) on the BIMS; had inattention and disorganized thinking that fluctuated; had no behaviors; and received antipsychotic, antianxiety, antidepressant and hypnotic drugs daily. a. The Plan of Care created on [DATE] documented, Focus: (Name of Resident) has a potential for adverse side effects d/t (due to) daily use of antipsychotic as per MD orders for her DX (diagnosis) of [MEDICAL CONDITION] and [MEDICAL CONDITION] Disorder; . Interventions: Administer anti-psychotic as per MD order monitoring and observing for adverse side effects, notifying MD as indicated . b. The Order Summary Report for [DATE] documented, [MEDICATION NAME] tablet: Give 150 mg by mouth at bedtime . (Start date [DATE]) . [MEDICATION NAME] tablet: Give 50 mg by mouth in the morning . (Start date [DATE]) . There were no documented orders for a CBC with Differential to be drawn weekly to monitor for blood dyscrasias with [MEDICATION NAME]. c. A CBC with Diff dated [DATE] was in the clinical record. There were no results for any CBC with Diff in the record since that date. d. The [DATE] MAR indicated [REDACTED]. e. The [DATE] MAR indicated [REDACTED]. f. The electronic medical record progress notes documented as follows: [DATE] 6:25 a.m. Refused AM (morning) meds. [DATE] 20:01 (8:01 p.m.) Blood drawn - have not received med. (medication) from pharmacy. [DATE] 00:58 (a.m.) . Resident up in w/c (wheelchair) in DR (dining room) at this time. Talking to people that are not there. Also making loud animal sounds and screaming at herself. [DATE] 21:13 (9:13 p.m.) [MEDICATION NAME] (sic) not available. [DATE] 05:49 (a.m.) [MEDICATION NAME] (sic) not available. [DATE] 05:53 (a.m.) Not available. g. On [DATE] at 8:45 a.m., RN #1 was asked for copies of any CBC with Diff since the date on the results in the clinical record, but copies were not provided by the time of exit. 9. Resident #21 had [DIAGNOSES REDACTED]. a. The [DATE] Order Summary Report documented, [MEDICATION NAME] Tablet 100mg 3.5 tablets by mouth at bedtime . CBC Q week every day shift every Mon (Monday) for [MEDICATION NAME] Refill. b. The Plan of Care revised on [DATE] documented, Focus: (Name of Resident) has a potential for adverse side effects d/t daily use of antipsychotic as per MD orders for his dx of [MEDICAL CONDITION]. Interventions: Administer antipsychotic medication as ordered by physician. Monitor for side effects and effectiveness . c. A CBC with Diff dated [DATE] was in the resident's clinical record. There were no results for any other CBC performed in the record since that date. d. The [DATE] MAR indicated [REDACTED]. e. The electronic medical record progress notes were reviewed and documented as follows: [DATE] 19:57 (7:57 p.m.) Unable to administer. [MEDICATION NAME] (sic) not available. [DATE] 20:11 (8:11 p.m.) Gamma Lab here to venipuncture resident for CBC. [DATE] 23:57 (11:57 p.m.) Received results of CBC/diff and was faxed to (Name of pharmacy). [DATE] 20:06 (8:06 p.m.) Blood drawn - haven't received med from pharm (pharmacy). [DATE] 21:11 (9:11 p.m.) Scheduled lab not drawn nor scheduled [MEDICATION NAME] not available at this time. f. On [DATE] at 8:45 a.m., RN #1 was asked for copies of any CBC with Diff since the date on the results ([DATE]) in the clinical record, but copies were not provided by the time of exit. 10. On [DATE] at 1:53, a telephone interview with a pharmacy representative, Pharmacist #1 was asked, Is there a reason the [MEDICATION NAME] was not sent to the residents? Pharmacist #1 stated, Probably the blood work. Pharmacist #1 was asked, Do they (the facility) fax the blood work to the pharmacy and then you dispense? The Pharmacist stated, We enter the blood work into a national [MEDICATION NAME] database. We can't dispense it unless we have a CBC with differential. 11. The Immediate Jeopardy was removed , and the Scope/Severity was lowered to an H on [DATE] at 3:00 p.m., when the facility implemented the following plan of removal. a. The Director of Nursing/Assistant Director of Nursing and RN (Registered Nurse) Treatment nurse were inserviced on the protocol for PT/INR and the PT/INR deviation sheet by the Corporate Quality Improvement Coordinator on [DATE] at 11:00 a.m The inservice included verification by the nurse that the results of the PT/INR were confirmed before giving the medication and if the lab was out of parameters or there was no results then they are to contact the physician to determine medication order for [MEDICATION NAME] and other items noted. b. Each of the five (5) residents medical records, who are on anticoagulation therapy were checked by Assistant Director of Nursing and/or RN Treatment nurse on [DATE] from 2:30 p.m., to 4:00 p.m for correct orders, Electronic medical record and medication cart accuracy. c. All resident receiving [MEDICATION NAME] were assessed on [DATE] from 11:15 a.m., to 2:26 p.m by the Assistant Director of Nursing and/or Registered Nurse treatment nurse with no abnormal findings. d. The medication carts (3) were audited for correct [MEDICATION NAME] dosages for the five (5) residents on [DATE] by the Assistant Director of Nursing and/or RN Treatment Nurse e. The PT/INR deviation sheet was put into use by the Assistant Director Of Nurses and/or RN Treatment nurse on [DATE] at 11:15 a.m All nursing working the current shift were inserviced on the PT/INR deviation sheet by the Assistant Director of Nurses and/or RN Treatment Nurse on [DATE] at 11:15 a.m The inservice included verification by the nurse that the results of the PT/INR were confirmed before giving the medication and if the lab was out of parameters or there was no results then they are to contact the physician to determine medication order for [MEDICATION NAME] and other items noted. All other licensed nurses will be inserviced by the Assistant Director of Nurses and/or RN Treatment Nurses before beginning his/her assigned shift and outgoing to include new employees and any employees returning from leave or absence. f., The physician, medical Director, was contacted on [DATE] at 11:30 a.m., by the Director of Nursing for all residents on anticoagulation therapy and an order was obtained to draw PT/INR. The lab company was contacted by the Director of Nursing and on [DATE] arrived in the facility to draw stat PT/INR's on all residents on anticoagulation therapy on [DATE] at 3:00 p.m g. The pharmacy was notified by the Director of Nursing on [DATE] and arrived at 2:00 p.m., of issue and a consultant pharmacist an audit of all medications to assure appropriate labs are being drawn for therapeutic medication levels h. The Director of Nursing and/or Assistant Director of Nursing will audit all [MEDICATION NAME] orders dosages given and any labs associated with [MEDICATION NAME] for 3 months. The DON/ ADON will audit 5 x week for 3 months starting on [DATE]. Results from audit will be presented at the monthly QAPI meeting for further evaluation and any abnormal findings will immediately be corrected and reported to Administrator and Medical Director.

F 0502 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	**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**

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NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
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F 0502

Level of harm - Immediate jeopardy

Residents Affected - Some

(continued... from page 12)
Complaint # (AR 585) and Complaint # (AR 590) were substantiated, all or in part, in these findings.
Based on observations, record review and interview, the facility failed to ensure laboratory services were promptly provided to ensure high risk medications ([MEDICATION NAME]) were monitored for potential toxic levels for 3 of 3 (Residents #17, #11 and #12) case mix residents who received anticoagulant therapy. The failed practice resulted in Immediate Jeopardy which caused or could have caused serious harm, injury or death to 1 (Resident #17) who expired [DATE] with a critically high INR and 2 (Residents #11 and #12) who had orders for [MEDICATION NAME] and no consistent PT/INR ([MEDICATION NAME]
Time/International Normalized Ratio) monitoring. The failed practice had the potential to cause more than minimal harm 5 residents who recieved anticoagulant therapy. The facility was notified of the Immediate Jeopardy on [DATE] at 9:53 a.m.
The facility also failed to ensure that laboratory work was performed to monitor for potentially harmful blood dyscrasias and to ensure pharmacy could continue to send the medication for 3 of 3 (Resident #13, #21, and #22) case mix residents who had orders for [MEDICATION NAME]. This failed practice had the potential to cause more than minimal harm for 3 residents in the facility who had orders for [MEDICATION NAME] according to the list provided by the Director of Nursing on [DATE].
The findings are:
1. On [DATE] at 4:00 p.m., the Director of Nurses stated the previous Lab company had notified her on [DATE] that they would no longer draw lab because they had not been paid. She stated that she called the corporate office and they told her, You are there, you handle it. She stated that she notified the local hospitals and they would not do it. She stated that she them called the Health Department and they told her that she would need more training. She stated that she found a business card for the Lab services that are now contracted with the facility.
2. On [DATE] at 4:17 p.m., a representative from the lab that refused to draw anymore lab since [DATE] was interveiwed. This person stated that the reason they stopped was because they had not received any payment since 2013.
3. According to the Nursing 2015 Drug Handbook, [MEDICATION NAME] is a Anticoagulants. For Administration of oral [MEDICATION NAME] PT/INR determinations are essential for proper control. The black Box warning documented [MEDICATION
NAME] can cause major or fatal bleeding. Regularly monitor INR in all patients.
4. Resident #17 had [DIAGNOSES REDACTED]. The Significant Change Minimum Data Set (MDS) with an Assessment Reference Date
(ARD) of [DATE] documented the resident scored 15 (,[DATE] indicates cognitively intact) on the Brief Interview for Mental Status (BIMS); was independent with activities of daily living, and received anticoagulant therapy 2 days of the past 7 days.
a. A physician's order dated [DATE] documented, [MEDICATION NAME] Sodium 6 mg (milligrams) give 1 tablet by mouth one time a
day for [MEDICAL CONDITION] give with 7.5 mg tab = (equals) 13.5 mg. Another physician's order dated [DATE] documented, [MEDICATION NAME] Sodium tablet 7.5 mg give 1 tablet one time a day for [MEDICAL CONDITION]. Give with 6 mg to = 13.5 mg.
b. The temporary plan of care for the resident dated [DATE] did not address the Anticoagulant therapy or the risk factors associated with anticoagulant therapy.
c. The [DATE] Medication Administration Record [REDACTED]. The MAR indicated [REDACTED]. The MAR indicated [REDACTED]. One
time only for therapeutic levels for 1 day. This was administered one time on [DATE]. However, there was no physician order in the clinical record to do this.
d. The [DATE] MAR indicated [REDACTED]. The June MAR indicated [REDACTED].
e. A PT/INR results dated [DATE] documented the [MEDICATION NAME] as 49 (10XXX,[DATE].1 normal range) and the INR as 4.45
(0XXX,[DATE].2 normal range). The physician wrote on the lab sheet to hold ([MEDICATION NAME]) and repeat (PT/INR) in 3 days.
f. The PT/INR results dated [DATE] was [MEDICATION NAME] 15.8 and the INR as 1.39. The physician wrote on the lab slip to increase to 11 mg for one week and then repeat the INR. (The [DATE] MAR indicated [REDACTED]
A physician's telephone order dated [DATE] documented [MEDICATION NAME] 11 mg po (oral) x (times) 1 week and repeat PT/INR
as scheduled. The [DATE] MAR indicated [REDACTED].
g. The next PT/INR's were drawn on [DATE], [DATE] and [DATE] and the physician initialed the lab slips.
A telephone order that was not dated documented, Increase [MEDICATION NAME] 10.5 mg x one week and repeat PT/INR x 7 days.
h. Nurses notes dated [DATE] at 7:53 p.m., documented, Lab results called to on call APN (Advanced Practice Nurse) at 12:40 p.m No N.O. (new orders) received at this time. Resident later observed to be lethargic VS (vital signs) 100.3, 85, 20 ,[DATE], pulse ox 70 to 93% on O2 (oxygen). Order received to TF (transfer) to hospital. EMS (Emergency Medical Services) notified of transfer at 1:56 a.m.
i. On [DATE] the resident was readmitted to the facility with orders for [MEDICATION NAME] 7.5 mg give 2 tablets to = 15 mg and [MEDICATION NAME] 06 mg/0.6Ml (milliliter) - give 0.6 ml SQ (subcutaneous) daily. PT/INR daily until INR is between 2.0 -3.0, then once therapeutic level reached D/C (discontinue) [MEDICATION NAME].
The [DATE] MAR indicated [REDACTED]. The August MAR indicated [REDACTED]. However, the pharmacy stated that they sent out 7
doses on [DATE].
j. The next PT/INR dated [DATE] documented INR of 1.85. The physician hand wrote an order Increase to 15.5 mg daily x 7 days and repeat PT/INR.
The August [DATE] documented the resident received 15 mg of [MEDICATION NAME] instead of 15.5 mg from [DATE] - [DATE],
[DATE], and [DATE] - [DATE] at 5 p.m. (held on [DATE], [DATE], and [DATE]). The MAR indicated [REDACTED].
k. The next PT/INR was drawn on [DATE] and the INR was documented as 1.94.
A physician's order dated [DATE] to documented, D/C (discontinue) [MEDICATION NAME] R/T (related to) INR 2.3. (INR results was 1.94 not 2.3)
l. The PT/INR results dated [DATE] documented the INR at 3.16. The PT/INR results dated [DATE] documented the INR as 4.04. There was no documentation on the lab sheet or the nurses notes that the physician or APN was notified of these results. A physician's order dated [DATE] at 10:06 a.m. documented to hold [MEDICATION NAME] for 2 days. Note: The [DATE] MAR indicated [REDACTED].
m. Nurses notes dated [DATE] documented, At 4:55 p.m., call placed to on-call APN and report given of concern about [MEDICATION NAME] dose with last INR greater that 4.0 (the one done on [DATE]). Received order to send R (resident) to ER (emergency room) for PT/INR lab draw. Order noted DON (Director of Nursing) and Administrator notified of TF (transfer) order. R (Resident) informed order to TF to ER (emergency room) for lab draw, and the need to find out where the current INR was before resuming dose. R made informed decision to refuse TF for lab draw. At 5:09 p.m., APN informed of R's refusal to TF out for lab. Received order to hold [MEDICATION NAME] until lab draw results received tomorrow. FU (follow-up) with on-call. Note: The [DATE] MAR indicated [REDACTED].
n. Nurses notes dated [DATE] at 6:55 p.m., documented, CNA (Certified Nursing Assistant) reported R was not breathing. Observed R in bed, w/o (with-out) respiration or pulse. Code Blue room [ROOM NUMBER] east paged over intercom. Call placed to (local ambulance service) report given this is (name of LPN) at (name of facility) (address of facility), I have a code blue situation in room [ROOM NUMBER] east. It is a bariatric patient send assistance. CPR initiated, EMS arrived, report given R TF to stretcher per staff and EMS. R out of building at 7:13 p.m. (name of family member) notified of TR at 7:15 p.m. Report called to (initials of hospital), Dr (name) notified of pronouncement at 8:19 p.m APN notified at 8:20 p.m.
o. A lab results collected on [DATE] at 1:10 p.m. documented INR of 6.02 High and [MEDICATION NAME] 53.4 High. This form documented, Results successfully called to (initials of lab contracted by the facility) at 8:21 p.m
On [DATE] at 4:00 p.m., the Director of Nurses stated that she called the lab and they told her that the reason the facility was not notified of the High INR was that they had no telephone number or anyway to contact the facility.
5. Resident #11 had a [DIAGNOSES REDACTED]. The Annual MDS with ARD of [DATE] documented the resident scored of 6 (,[DATE]
indicates severe impairment) on the BIMS, required limited assistance with bed mobility and extensive assistance with dressing, was independent with the remainder of activities of daily living, and received an anticoagulant 7 days in the past 7 days.
a. The Plan of Care developed [DATE] documented a problem of, The resident is on anticoagulant Therapy [MEDICATION NAME] with interventions that included Administer Anticoagulant medications as ordered by the physician and Labs as ordered. Report abnormal lab results to MD.
b. A physician's order dated [DATE] documented, [MEDICATION NAME] 4 mg daily x 1 week. Repeat PT/INR as scheduled.
c. A lab report dated [DATE] documented the PT as 17.8 and the INR as 1.57. There was a physician's order dated [DATE] to increase the [MEDICATION NAME] to 5 mg daily and continue weekly PT/INR. The [DATE] MAR indicated [REDACTED].
d. A physician's order dated [DATE] documented, Increase [MEDICATION NAME] to 5.5 mg daily and repeat PT/INR in 7 days.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045314	A. BUILDING _____ B. WING _____	**08/28/2015**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
RED OAK HEALTHCARE AND REHAB, LLC	**1010 BARNES STREET LONOKE, AR 72086**

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 0502

Level of harm - Immediate jeopardy

Residents Affected - Some

(continued... from page 13)
e. The next PT/INR was drawn on [DATE] (5 days later than when ordered).
f. The lab results dated [DATE] documented the [MEDICATION NAME] was 40.3 and the INR was 3.64. There was a hand written order on the lab slip that documented, Hold PT/INR ([MEDICATION NAME]? not clarified by facility) x 2 days and repeat PT/INR. The [DATE] MAR indicated [REDACTED].
g. A physician's order dated [DATE] documented, D/C (discontinue) [MEDICATION NAME] 5.5 mg and start [MEDICATION NAME] 4 mg
one po at 5:00 p.m. and redraw PT/INR on [DATE].
h. The next PT/INR was drawn on [DATE], four days later than ordered.
6. Resident #12 had a [DIAGNOSES REDACTED].
a. The Plan of Care updated on [DATE] documented a problem of, Daily anticoagulant as per MD orders for CAD ([MEDICAL CONDITION]) with potential for easily bleeding and or bruising with interventions that included Administer meds as ordered, obtain and monitor/diagnostic work as ordered. Report results to MD and follow-up as ordered.
b. A physician's order dated [DATE] documented, Increase [MEDICATION NAME] to 10 mg daily for 7 days and Repeat PT/INR as scheduled.
c. Lab results dated [DATE] documented [MEDICATION NAME] 15.3 and INR 1.34. There was a hand written order on the form to increase [MEDICATION NAME] to 10.5 mg daily and repeat PT/INR in 7 days.
The [DATE] MAR indicated [REDACTED].
The MAR indicated [REDACTED].
d. On [DATE] at 2:00 p.m., the resident's medication from the cart was reviewed. There was only one card of [MEDICATION NAME] 10 mg in the cart.
On [DATE] at 11:25 a.m., the pharmacy tech stated that the [MEDICATION NAME] 0.5 mg was sent out on the 11th. She further stated that they send enough for 7 doses and then received information from the facility that it was discontinued on [DATE].
There was no documentation in the nurses notes or lab slips that the dose had been decreased to 10 mg. The MAR indicated [REDACTED].
e. The next PT/INR was drawn [DATE] instead of on the 17th as ordered.
7. Resident #13 had [DIAGNOSES REDACTED].
a. The Order Summary Report for [DATE] documented, [MEDICATION NAME] tablet 100 mg: Give 1.5 tablet by mouth at bedtime .
(start date [DATE]). [MEDICATION NAME] tablet 50 mg. Give 1 tablet by mouth one time a day . (start date [DATE]) . CBC (complete blood count) with diff (differential) with absolute neuraphil (sic) count weekly x 6 months. Start Date [DATE].
b. The clinical record had copies of lab results for a CBC with Diff that was performed on [DATE], [DATE], [DATE] and [DATE]. There were no results in the record for any CBC with Diff after [DATE] order would not have been discontinued until [DATE].
c. The [DATE] MAR indicated [REDACTED]. The MAR indicated [REDACTED].
d. The [DATE] MAR indicated [REDACTED]. The MAR indicated [REDACTED].
e. The electronic medical record progress notes were reviewed on [DATE] and documented as follows:
[DATE] 21:52 (9:52 p.m.) WBC (White Blood Count) (with) Diff (differential) faxed to Central Pharmacy.
[DATE] 21:15 (9:15 p.m.) [MEDICATION NAME] (sic) not available.
[DATE] 9:06 a.m. Unavailable at this time.
[DATE] 9:07 a.m. Unavailable at this time.
f. On [DATE] at 8:45 a.m., Registered Nurse (RN) #1 was asked, Why are there skips in the [MEDICATION NAME] (administration)? RN #1 stated, I'm not sure why. [MEDICATION NAME] is an antipsychotic and needs a CBC. Copies of the CBC with diff performed since [DATE] were requested but not provided by the time of exit.
8. Resident #22 had [DIAGNOSES REDACTED]. The Admission MDS with an ARD of [DATE] documented the resident scored 11 (,[DATE]
indicates moderately impaired) on the BIMS; had inattention and disorganized thinking that fluctuated; had no behaviors; and received antipsychotic, antianxiety, antidepressant and hypnotic drugs daily.
a. The Plan of Care created on [DATE] documented, Focus: (Name of Resident) has a potential for adverse side effects d/t (due to) daily use of antipsychotic as per MD orders for her DX (diagnosis) of [MEDICAL CONDITION] and [MEDICAL CONDITION]
Disorder; . Interventions: Administer anti-psychotic as per MD order monitoring and observing for adverse side effects, notifying MD as indicated .
b. The Order Summary Report for [DATE] documented, [MEDICATION NAME] tablet: Give 150 mg by mouth at bedtime . (Start date
[DATE]) . [MEDICATION NAME] tablet: Give 50 mg by mouth in the morning . (Start date [DATE]) .
There were no documented orders for a CBC with Differential to be drawn weekly to monitor for blood dyscrasias with [MEDICATION NAME].
c. A CBC with Diff dated [DATE] was in the clinical record. There were no results for any CBC with Diff in the record since that date.
d. The [DATE] MAR indicated [REDACTED].
e. The [DATE] MAR indicated [REDACTED].
f. The electronic medical record progress notes documented as follows:
[DATE] 6:25 a.m. Refused AM (morning) meds.
[DATE] 20:01 (8:01 p.m.) Blood drawn - have not received med. (medication) from pharmacy.
[DATE] 00:58 (a.m.) . Resident up in w/c (wheelchair) in DR (dining room) at this time. Talking to people that are not there. Also making loud animal sounds and screaming at herself.
[DATE] 21:13 (9:13 p.m.) [MEDICATION NAME] (sic) not available.
[DATE] 05:49 (a.m.) [MEDICATION NAME] (sic) not available.
[DATE] 05:53 (a.m.) Not available.
g. On [DATE] at 8:45 a.m., RN #1 was asked for copies of any CBC with Diff since the date on the results in the clinical record, but copies were not provided by the time of exit.
9. Resident #21 had [DIAGNOSES REDACTED].
a. The [DATE] Order Summary Report documented, [MEDICATION NAME] Tablet 100mg 3.5 tablets by mouth at bedtime . CBC Q week
every day shift every Mon (Monday) for [MEDICATION NAME] Refill.
b. The Plan of Care revised on [DATE] documented, Focus: (Name of Resident) has a potential for adverse side effects d/t daily use of antipsychotic as per MD orders for his dx of [MEDICAL CONDITION]. Interventions: Administer antipsychotic medication as ordered by physician. Monitor for side effects and effectiveness .
c. A CBC with Diff dated [DATE] was in the resident's clinical record. There were no results for any other CBC performed in the record since that date.
d. The [DATE] MAR indicated [REDACTED].
e. The electronic medical record progress notes were reviewed and documented as follows:
[DATE] 19:57 (7:57 p.m.) Unable to administer. [MEDICATION NAME] (sic) not available.
[DATE] 20:11 (8:11 p.m.) Gamma Lab here to venipuncture resident for CBC.
[DATE] 23:57 (11:57 p.m.) Received results of CBC/diff and was faxed to (Name of pharmacy).
[DATE] 20:06 (8:06 p.m.) Blood drawn - haven't received med from pharm (pharmacy).
[DATE] 21:11 (9:11 p.m.) Scheduled lab not drawn nor scheduled [MEDICATION NAME] not available at this time.
f. On [DATE] at 8:45 a.m., RN #1 was asked for copies of any CBC with Diff since the date on the results ([DATE]) in the clinical record, but copies were not provided by the time of exit.
10. On [DATE] at 1:53, a telephone interview with a pharmacy representative, Pharmacist #1 was asked, Is there a reason the [MEDICATION NAME] was not sent to the residents? Pharmacist #1 stated, Probably the blood work. Pharmacist #1 was asked, Do they (the facility) fax the blood work to the pharmacy and then you dispense? The Pharmacist stated, We enter the blood work into a national [MEDICATION NAME] database. We can't dispense it unless we have a CBC with differential.
11. The Immediate Jeopardy was removed , and the Scope/Severity was lowered to an H on [DATE] at 3:00 p.m., when the facility implemented the following plan of removal.
a. The Director of Nursing/Assistant Director of Nursing and RN (Registered Nurse) Treatment nurse were inserviced on the protocol for PT/INR and the PT/INR deviation sheet by the Corporate Quality Improvement Coordinator on [DATE] at 11:00 a.m
The inservice included verification by the nurse that the results of the PT/INR were confirmed before giving the medication

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
RED OAK HEALTHCARE AND REHAB, LLC	**1010 BARNES STREET LONOKE, AR 72086**

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 0502 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 14) and if the lab was out of parameters or there was no results then they are to contact the physician to determine medication order for [MEDICATION NAME] and other items noted. b. Each of the five (5) residents medical records, who are on anticoagulation therapy were checked by Assistant Director of Nursing and/or RN Treatment nurse on [DATE] from 2:30 p.m., to 4:00 p.m for correct orders, Electronic medical record and medication cart accuracy. c. All resident receiving [MEDICATION NAME] were assessed on [DATE] from 11:15 a.m., to 2:26 p.m by the Assistant Director of Nursing and/or Registered Nurse treatment nurse with no abnormal findings. d. The medication carts (3) were audited for correct [MEDICATION NAME] dosages for the five (5) residents on [DATE] by the Assistant Director of Nursing and/or RN Treatment Nurse e. The PT/INR deviation sheet was put into use by the Assistant Director Of Nurses and/or RN Treatment nurse on [DATE] at 11:15 a.m All nursing working the current shift were inserviced on the PT/INR deviation sheet by the Assistant Director of Nurses and/or RN Treatment Nurse on [DATE] at 11:15 a.m The inservice included verification by the nurse that the results of the PT/INR were confirmed before giving the medication and if the lab was out of parameters or there was no results then they are to contact the physician to determine medication order for [MEDICATION NAME] and other items noted. All other licensed nurses will be inserviced by the Assistant Director of Nurses and/or RN Treatment Nurses before beginning his/her assigned shift and outgoing to include new employees and any employees returning from leave or absence. f., The physician, medical Director, was contacted on [DATE] at 11:30 a.m., by the Director of Nursing for all residents on anticoagulation therapy and an order was obtained to draw PT/INR. The lab company was contacted by the Director of Nursing and on [DATE] arrived in the facility to draw stat PT/INR's on all residents on anticoagulation therapy on [DATE] at 3:00 p.m g. The pharmacy was notified by the Director of Nursing on [DATE] and arrived at 2:00 p.m., of issue and a consultant pharmacist an audit of all medications to assure appropriate labs are being drawn for therapeutic medication levels h. The Director of Nursing and/or Assistant Director of Nursing will audit all [MEDICATION NAME] orders dosages given and any labs associated with [MEDICATION NAME] for 3 months. The DON/ ADON will audit 5 x week for 3 months starting on [DATE]. Results from audit will be presented at the monthly QAPI meeting for further evaluation and any abnormal findings will immediately be corrected and reported to Administrator and Medical Director.

F 0520 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	**Set up an ongoing quality assessment and assurance group to review quality deficiencies quarterly, and develop corrective plans of action.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Complaint # (AR 590) and Complaint # (AR 585) were substantiated, all or in part, in these findings. Based on observations, record review and interview the Quality Assessment and Assurance Committee failed to identify quality deficiencies as evidenced by the facility failure to ensure high risk medications ([MEDICATION NAME]) were monitored for potential toxic levels and were given or held as prescribed by the physician to ensure accuracy of using lab results to determine most effective dose for 3 of 3 (Residents #17, #11 and #12) case mix residents who received anticoagulant therapy. The failed practice resulted in Immediate Jeopardy which caused or could have caused serious harm, injury or death to 1 (Resident #17) who expired [DATE] with a critically high INR and 2 (Residents #11 and #12) who had orders for [MEDICATION NAME] and no consistent PT/INR ([MEDICATION NAME] Time/International Normalized Ratio) monitoring. The failed practice had the potential to cause more than minimal harm 5 residents who received anticoagulant therapy. The facility was notified of the Immediate Jeopardy on [DATE] at 9:53 a.m. The facility also failed to ensure that laboratory work was performed to monitor for potentially harmful blood dyscrasias and to ensure pharmacy could continue to send the medication for 3 of 3 (Resident #13, #21, and #22) case mix residents who had orders for [MEDICATION NAME]. This failed practice had the potential to cause more than minimal harm for 3 residents in the facility who had orders for [MEDICATION NAME] according to the list provided by the Director of Nursing on [DATE]. The findings are: 1. On [DATE] at 9:00 a.m., the Administrator was interviewed regarding the QA &A Committee. He stated, All department heads, the Medical Director and the Assistant Director of Nursing were on the QA&A Committee. He was asked, Did the QA&A committee recognize any areas of concern related to [MEDICATION NAME] (anticoagulant therapy) and lab? He stated, Part of the committee did, discussed with the Medical Director. He was asked, What was the action plan? He stated that it was to secure labs and get labs drawn. He stated that the committee did not identify any issues with medication administration. On [DATE] at 9:00 a.m., the Medical Director (member of the QA&A Committee) was interviewed. He was asked, Have you had any issues with the facility related to lab services? He stated, They told me they were switching in the last 2 weeks. I don't know where to call to get results. I'm not certain today where to send the lab to. He was asked, Have you had any problems with PT/INR's? He stated, I'm trying to remember. I guess it's the same lab thing. There was no evidence that the facility attempted to send the residents to a clinic or to the hospital outpatient to get labs drawn. On [DATE] at 4:00 p.m., the Director of Nurses stated the previous lab company had notified her on [DATE] that they would no longer draw lab because they had not been paid. She stated that she called the corporate office and they told her, You are there, you handle it. She stated that she notified the local hospitals and they would not do it. She stated that she them called the Health Department and they told her that she would need more training. She stated that she found a business card for the lab services that are now contracted with the facility. On [DATE] at 4:17 p.m., a representative from the lab that refused to draw anymore lab since [DATE] was interviewed. This person stated that the reason they stopped was because they had not received any payment since 2013. 2. According to the Nursing 2015 Drug Handbook, [MEDICATION NAME] is a Anticoagulants. For Administration of oral [MEDICATION NAME] PT/INR determinations are essential for proper control. The black Box warning documented [MEDICATION NAME] can cause major or fatal bleeding. Regularly monitor INR in all patients. 3. Resident #17 had [DIAGNOSES REDACTED]. The Significant Change Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of [DATE] documented the resident scored 15 (,[DATE] indicates cognitively intact) on the Brief Interview for Mental Status (BIMS); was independent with activities of daily living, and received anticoagulant therapy 2 days of the past 7 days. a. A physician's order dated [DATE] documented, [MEDICATION NAME] Sodium 6 mg (milligrams) give 1 tablet by mouth one time a day for [MEDICAL CONDITION] give with 7.5 mg tab = (equals) 13.5 mg. Another physician's order dated [DATE] documented, [MEDICATION NAME] Sodium tablet 7.5 mg give 1 tablet one time a day for [MEDICAL CONDITION]. Give with 6 mg to = 13.5 mg. b. The temporary plan of care for the resident dated [DATE] did not address the Anticoagulant therapy or the risk factors associated with anticoagulant therapy. c. The [DATE] Medication Administration Record [REDACTED]. The MAR indicated [REDACTED]. The MAR indicated [REDACTED]. One time only for therapeutic levels for 1 day. This was administered one time on [DATE]. However, there was no physician order in the clinical record to do this. d. The [DATE] MAR indicated [REDACTED]. The June MAR indicated [REDACTED]. e. A PT/INR results dated [DATE] documented the [MEDICATION NAME] as 49 (10XXX,[DATE].1 normal range) and the INR as 4.45 (0XXX,[DATE].2 normal range). The physician wrote on the lab sheet to hold ([MEDICATION NAME]) and repeat (PT/INR) in 3 days. f. The PT/INR results dated [DATE] was [MEDICATION NAME] 15.8 and the INR as 1.39. The physician wrote on the lab slip to increase to 11 mg for one week and then repeat the INR. (The [DATE] MAR indicated [REDACTED] A physician's telephone order dated [DATE] documented [MEDICATION NAME] 11 mg po (oral) x (times) 1 week and repeat PT/INR as scheduled. The [DATE] MAR indicated [REDACTED]. g. The next PT/INR's were drawn on [DATE], [DATE] and [DATE] and the physician initialed the lab slips. A telephone order that was not dated documented, Increase [MEDICATION NAME] 10.5 mg x one week and repeat PT/INR x 7 days. h. Nurses notes dated [DATE] at 7:53 p.m., documented, Lab results called to on call APN (Advanced Practice Nurse) at 12:40 p.m No N.O. (new orders) received at this time. Resident later observed to be lethargic VS (vital signs) 100.3, 85, 20 ,[DATE], pulse ox 70 to 93% on O2 (oxygen). Order received to TF (transfer) to hospital. EMS (Emergency Medical Services) notified of transfer at 1:56 a.m.

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F 0520

Level of harm - Immediate jeopardy

Residents Affected - Some

(continued... from page 15)
i. On [DATE] the resident was readmitted to the facility with orders for [MEDICATION NAME] 7.5 mg give 2 tablets to = 15 mg and [MEDICATION NAME] 06 mg/0.6Ml (milliliter) - give 0.6 ml SQ (subcutaneous) daily. PT/INR daily until INR is between 2.0 -3.0, then once therapeutic level reached D/C (discontinue) [MEDICATION NAME].
The [DATE] MAR indicated [REDACTED]. The August MAR indicated [REDACTED]. However, the pharmacy stated that they sent out 7
doses on [DATE].
j. The next PT/INR dated [DATE] documented INR of 1.85. The physician hand wrote an order Increase to 15.5 mg daily x 7 days and repeat PT/INR.
The August [DATE] documented the resident received 15 mg of [MEDICATION NAME] instead of 15.5 mg from [DATE] - [DATE],
[DATE], and [DATE] - [DATE] at 5 p.m. (held on [DATE], [DATE], and [DATE]). The MAR indicated [REDACTED].
k. The next PT/INR was drawn on [DATE] and the INR was documented as 1.94.
A physician's order dated [DATE] to documented, D/C (discontinue) [MEDICATION NAME] R/T (related to) INR 2.3. (INR results was 1.94 not 2.3)
l. The PT/INR results dated [DATE] documented the INR at 3.16. The PT/INR results dated [DATE] documented the INR as 4.04. There was no documentation on the lab sheet or the nurses notes that the physician or APN was notified of these results. A physician's order dated [DATE] at 10:06 a.m. documented to hold [MEDICATION NAME] for 2 days. Note: The [DATE] MAR indicated [REDACTED].
m. Nurses notes dated [DATE] documented, At 4:55 p.m., call placed to on-call APN and report given of concern about [MEDICATION NAME] dose with last INR greater that 4.0 (the one done on [DATE]). Received order to send R (resident) to ER (emergency room) for PT/INR lab draw. Order noted DON (Director of Nursing) and Administrator notified of TF (transfer) order. R (Resident) informed order to TF to ER (emergency room) for lab draw, and the need to find out where the current INR was before resuming dose. R made informed decision to refuse TF for lab draw. At 5:09 p.m., APN informed of R's refusal to TF out for lab. Received order to hold [MEDICATION NAME] until lab draw results received tomorrow. FU (follow-up) with on-call. Note: The [DATE] MAR indicated [REDACTED].
n. Nurses notes dated [DATE] at 6:55 p.m., documented, CNA (Certified Nursing Assistant) reported R was not breathing. Observed R in bed, w/o (with-out) respiration or pulse. Code Blue room [ROOM NUMBER] east paged over intercom. Call placed to (local ambulance service) report given this is (name of LPN) at (name of facility) (address of facility), I have a code blue situation in room [ROOM NUMBER] east. It is a bariatric patient send assistance. CPR initiated, EMS arrived, report given R TF to stretcher per staff and EMS. R out of building at 7:13 p.m. (name of family member) notified of TR at 7:15 p.m. Report called to (initials of hospital), Dr (name) notified of pronouncement at 8:19 p.m APN notified at 8:20 p.m.
o. A lab results collected on [DATE] at 1:10 p.m. documented INR of 6.02 High and [MEDICATION NAME] 53.4 High. This form documented, Results successfully called to (initials of lab contracted by the facility) at 8:21 p.m
On [DATE] at 4:00 p.m., the Director of Nurses stated that she called the lab and they told her that the reason the facility was not notified of the High INR was that they had no telephone number or anyway to contact the facility.
4. Resident #11 had a [DIAGNOSES REDACTED]. The Annual MDS with ARD of [DATE] documented the resident scored of 6 (,[DATE]
indicates severe impairment) on the BIMS, required limited assistance with bed mobility and extensive assistance with dressing, was independent with the remainder of activities of daily living, and received an anticoagulant 7 days in the past 7 days.
a. The Plan of Care developed [DATE] documented a problem of, The resident is on anticoagulant Therapy [MEDICATION NAME] with interventions that included Administer Anticoagulant medications as ordered by the physician and Labs as ordered. Report abnormal lab results to MD.
b. A physician's order dated [DATE] documented, [MEDICATION NAME] 4 mg daily x 1 week. Repeat PT/INR as scheduled.
c. A lab report dated [DATE] documented the PT as 17.8 and the INR as 1.57. There was a physician's order dated [DATE] to increase the [MEDICATION NAME] to 5 mg daily and continue weekly PT/INR. The [DATE] MAR indicated [REDACTED].
d. A physician's order dated [DATE] documented, Increase [MEDICATION NAME] to 5.5 mg daily and repeat PT/INR in 7 days.
e. The next PT/INR was drawn on [DATE] (5 days later than when ordered).
f. The lab results dated [DATE] documented the [MEDICATION NAME] was 40.3 and the INR was 3.64. There was a hand written order on the lab slip that documented, Hold PT/INR ([MEDICATION NAME]? not clarified by facility) x 2 days and repeat PT/INR. The [DATE] MAR indicated [REDACTED].
g. A physician's order dated [DATE] documented, D/C (discontinue) [MEDICATION NAME] 5.5 mg and start [MEDICATION NAME] 4 mg
one po at 5:00 p.m. and redraw PT/INR on [DATE].
h. The next PT/INR was drawn on [DATE], four days later than ordered.
5. Resident #12 had a [DIAGNOSES REDACTED].
a. The Plan of Care updated on [DATE] documented a problem of, Daily anticoagulant as per MD orders for CAD ([MEDICAL CONDITION]) with potential for easily bleeding and or bruising with interventions that included Administer meds as ordered, obtain and monitor/diagnostic work as ordered. Report results to MD and follow-up as ordered.
b. A physician's order dated [DATE] documented, Increase [MEDICATION NAME] to 10 mg daily for 7 days and Repeat PT/INR as scheduled.
c. Lab results dated [DATE] documented [MEDICATION NAME] 15.3 and INR 1.34. There was a hand written order on the form to increase [MEDICATION NAME] to 10.5 mg daily and repeat PT/INR in 7 days.
The [DATE] MAR indicated [REDACTED].
The MAR indicated [REDACTED].
d. On [DATE] at 2:00 p.m., the resident's medication from the cart was reviewed. There was only one card of [MEDICATION NAME] 10 mg in the cart.
On [DATE] at 11:25 a.m., the pharmacy tech stated that the [MEDICATION NAME] 0.5 mg was sent out on the 11th. She further stated that they send enough for 7 doses and then received information from the facility that it was discontinued on [DATE].
There was no documentation in the nurses notes or lab slips that the dose had been decreased to 10 mg. The MAR indicated [REDACTED].
e. The next PT/INR was drawn [DATE] instead of on the 17th as ordered.
6. Resident #13 had [DIAGNOSES REDACTED].
a. The Order Summary Report for [DATE] documented, [MEDICATION NAME] tablet 100 mg: Give 1.5 tablet by mouth at bedtime .
(start date [DATE]). [MEDICATION NAME] tablet 50 mg. Give 1 tablet by mouth one time a day . (start date [DATE]) . CBC (complete blood count) with diff (differential) with absolute neuraphil (sic) count weekly x 6 months. Start Date [DATE].
b. The clinical record had copies of lab results for a CBC with Diff that was performed on [DATE], [DATE], [DATE] and [DATE]. There were no results in the record for any CBC with Diff after [DATE] order would not have been discontinued until [DATE].
c. The [DATE] MAR indicated [REDACTED]. The MAR indicated [REDACTED].
d. The [DATE] MAR indicated [REDACTED]. The MAR indicated [REDACTED].
e. The electronic medical record progress notes were reviewed on [DATE] and documented as follows:
[DATE] 21:52 (9:52 p.m.) WBC (White Blood Count) (with) Diff (differential) faxed to Central Pharmacy.
[DATE] 21:15 (9:15 p.m.) [MEDICATION NAME] (sic) not available.
[DATE] 9:06 a.m. Unavailable at this time.
[DATE] 9:07 a.m. Unavailable at this time.
f. On [DATE] at 8:45 a.m., Registered Nurse (RN) #1 was asked, Why are there skips in the [MEDICATION NAME] (administration)? RN #1 stated, I'm not sure why. [MEDICATION NAME] is an antipsychotic and needs a CBC. Copies of the CBC with diff performed since [DATE] were requested but not provided by the time of exit.
7. Resident #22 had [DIAGNOSES REDACTED]. The Admission MDS with an ARD of [DATE] documented the resident scored 11 (,[DATE]
indicates moderately impaired) on the BIMS; had inattention and disorganized thinking that fluctuated; had no behaviors; and received antipsychotic, antianxiety, antidepressant and hypnotic drugs daily.
a. The Plan of Care created on [DATE] documented, Focus: (Name of Resident) has a potential for adverse side effects d/t (due to) daily use of antipsychotic as per MD orders for her DX (diagnosis) of [MEDICAL CONDITION] and [MEDICAL CONDITION]
Disorder; . Interventions: Administer anti-psychotic as per MD order monitoring and observing for adverse side effects, notifying MD as indicated .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	045314	A. BUILDING _____ B. WING _____	08/28/2015

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
RED OAK HEALTHCARE AND REHAB, LLC	1010 BARNES STREET LONOKE, AR 72086

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 0520 **Level of harm** - Immediate jeopardy **Residents Affected** - Some	(continued... from page 16) b. The Order Summary Report for [DATE] documented, [MEDICATION NAME] tablet: Give 150 mg by mouth at bedtime . (Start date [DATE]) . [MEDICATION NAME] tablet: Give 50 mg by mouth in the morning . (Start date [DATE]) . There were no documented orders for a CBC with Differential to be drawn weekly to monitor for blood dyscrasias with [MEDICATION NAME]. c. A CBC with Diff dated [DATE] was in the clinical record. There were no results for any CBC with Diff in the record since that date. d. The [DATE] MAR indicated [REDACTED]. e. The [DATE] MAR indicated [REDACTED]. f. The electronic medical record progress notes documented as follows: [DATE] 6:25 a.m. Refused AM (morning) meds. [DATE] 20:01 (8:01 p.m.) Blood drawn - have not received med. (medication) from pharmacy. [DATE] 00:58 (a.m.) . Resident up in w/c (wheelchair) in DR (dining room) at this time. Talking to people that are not there. Also making loud animal sounds and screaming at herself. [DATE] 21:13 (9:13 p.m.) [MEDICATION NAME] (sic) not available. [DATE] 05:49 (a.m.) [MEDICATION NAME] (sic) not available. [DATE] 05:53 (a.m.) Not available. g. On [DATE] at 8:45 a.m., RN #1 was asked for copies of any CBC with Diff since the date on the results in the clinical record, but copies were not provided by the time of exit. 8. Resident #21 had [DIAGNOSES REDACTED]. a. The [DATE] Order Summary Report documented, [MEDICATION NAME] Tablet 100mg 3.5 tablets by mouth at bedtime . CBC Q week every day shift every Mon (Monday) for [MEDICATION NAME] Refill. b. The Plan of Care revised on [DATE] documented, Focus: (Name of Resident) has a potential for adverse side effects d/t daily use of antipsychotic as per MD orders for his dx of [MEDICAL CONDITION]. Interventions: Administer antipsychotic medication as ordered by physician. Monitor for side effects and effectiveness . c. A CBC with Diff dated [DATE] was in the resident's clinical record. There were no results for any other CBC performed in the record since that date. d. The [DATE] MAR indicated [REDACTED]. e. The electronic medical record progress notes were reviewed and documented as follows: [DATE] 19:57 (7:57 p.m.) Unable to administer. [MEDICATION NAME] (sic) not available. [DATE] 20:11 (8:11 p.m.) Gamma Lab here to venipuncture resident for CBC. [DATE] 23:57 (11:57 p.m.) Received results of CBC/diff and was faxed to (Name of pharmacy). [DATE] 20:06 (8:06 p.m.) Blood drawn - haven't received med from pharm (pharmacy). [DATE] 21:11 (9:11 p.m.) Scheduled lab not drawn nor scheduled [MEDICATION NAME] not available at this time. f. On [DATE] at 8:45 a.m., RN #1 was asked for copies of any CBC with Diff since the date on the results ([DATE]) in the clinical record, but copies were not provided by the time of exit. 9. On [DATE] at 1:53, a telephone interview with a pharmacy representative, Pharmacist #1 was asked, Is there a reason the [MEDICATION NAME] was not sent to the residents? Pharmacist #1 stated, Probably the blood work. Pharmacist #1 was asked, Do they (the facility) fax the blood work to the pharmacy and then you dispense? The Pharmacist stated, We enter the blood work into a national [MEDICATION NAME] database. We can't dispense it unless we have a CBC with differential. 10. The Immediate Jeopardy was removed , and the Scope/Severity was lowered to an H on [DATE] at 3:00 p.m., when the facility implemented the following plan of removal. a. The Director of Nursing/Assistant Director of Nursing and RN (Registered Nurse) Treatment nurse were inserviced on the protocol for PT/INR and the PT/INR deviation sheet by the Corporate Quality Improvement Coordinator on [DATE] at 11:00 a.m The inservice included verification by the nurse that the results of the PT/INR were confirmed before giving the medication and if the lab was out of parameters or there was no results then they are to contact the physician to determine medication order for [MEDICATION NAME] and other items noted. b. Each of the five (5) residents medical records, who are on anticoagulation therapy were checked by Assistant Director of Nursing and/or RN Treatment nurse on [DATE] from 2:30 p.m., to 4:00 p.m for correct orders, Electronic medical record and medication cart accuracy. c. All resident receiving [MEDICATION NAME] were assessed on [DATE] from 11:15 a.m., to 2:26 p.m by the Assistant Director of Nursing and/or Registered Nurse treatment nurse with no abnormal findings. d. The medication carts (3) were audited for correct [MEDICATION NAME] dosages for the five (5) residents on [DATE] by the Assistant Director of Nursing and/or RN Treatment Nurse e. The PT/INR deviation sheet was put into use by the Assistant Director Of Nurses and/or RN Treatment nurse on [DATE] at 11:15 a.m All nursing working the current shift were inserviced on the PT/INR deviation sheet by the Assistant Director of Nurses and/or RN Treatment Nurse on [DATE] at 11:15 a.m The inservice included verification by the nurse that the results of the PT/INR were confirmed before giving the medication and if the lab was out of parameters or there was no results then they are to contact the physician to determine medication order for [MEDICATION NAME] and other items noted. All other licensed nurses will be inserviced by the Assistant Director of Nurses and/or RN Treatment Nurses before beginning his/her assigned shift and outgoing to include new employees and any employees returning from leave or absence. f., The physician, medical Director, was contacted on [DATE] at 11:30 a.m., by the Director of Nursing for all residents on anticoagulation therapy and an order was obtained to draw PT/INR. The lab company was contacted by the Director of Nursing and on [DATE] arrived in the facility to draw stat PT/INR's on all residents on anticoagulation therapy on [DATE] at 3:00 p.m g. The pharmacy was notified by the Director of Nursing on [DATE] and arrived at 2:00 p.m., of issue and a consultant pharmacist an audit of all medications to assure appropriate labs are being drawn for therapeutic medication levels h. The Director of Nursing and/or Assistant Director of Nursing will audit all [MEDICATION NAME] orders dosages given and any labs associated with [MEDICATION NAME] for 3 months. The DON/ ADON will audit 5 x week for 3 months starting on [DATE]. Results from audit will be presented at the monthly QAPI meeting for further evaluation and any abnormal findings will immediately be corrected and reported to Administrator and Medical Director.