STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455934	A. BUILDING _____ B. WING _____	07/21/2016

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
NORTHERN OAKS LIVING & REHABILITATION CENTER	2722 OLD ANSON RD ABILENE, TX 79603

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0329 **Level of harm** - Actual harm **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** Based on interview and record review, the facility failed to ensure that four (Residents #1, #2, #3, and #4) of seven residents reviewed for unnecessary drugs received adequate monitoring while receiving [MEDICATION NAME] (a blood thinner). A. Resident #1 had an order, dated 04/28/16, to have his PT/INR levels tested every other Wednesday in the morning due to receiving [MEDICATION NAME]. Resident #1 did not have his PT/INR levels checked from the date of the order until 06/19/16 when he was discovered to have a bruise on his left arm that extended from his elbow to his wrist. Resident #1's PT/INR level was tested on [DATE] and the results revealed his INR level was critically high. Resident #1's PT/INR level was not checked between the test on 06/20/16 and his discharge to the hospital on [DATE]. Resident #1's PT/INR was checked at the hospital on [DATE] and his INR was 4.8, which was identified by the lab as critical. B. Resident #2 had an order, dated 03/24/16, to have his PT/INR levels tested every other Wednesday in the morning due to receiving [MEDICATION NAME]. Resident #2's PT/INR level was not checked between 04/13/16 and 05/16/16. Resident #2 did not receive two ordered lab test. C. Resident #3 had an order, dated 06/16/16, to have his PT/INR levels tested every other Wednesday in the morning due to receiving [MEDICATION NAME]. Resident #3's PT/INR was not tested from 06/16/16 until 07/20/16. Resident #3 did not receive two ordered lab test. D. Resident #4 had an order, dated 05/31/16, not to receive [MEDICATION NAME] until his INR was below 2.0. Resident #4 also had an order, dated 06/02/16, to have a PT/INR level tested on e time on 06/02/16. The PT /INR test ordered for 06/02/16 was not conducted, but Resident #4 continued to receive his [MEDICATION NAME] from 06/02/16 through 0614/16. Resident #4's PT/INR was not checked until 06/15/16. This failure could affect the seven residents receiving [MEDICATION NAME] by placing them at risk for receiving unnecessary doses of medication and experiencing undesirable side effects as well as potentially causing undetected health issues, delayed treatment, uncontrolled bleeding, and death. Findings included: Resident #1 Record review of Resident #1's Admission Record, undated, revealed he was an [AGE] year old male admitted to the facility on [DATE]. His [DIAGNOSES REDACTED]. Record review of Resident #1's Admission Minimum Data Set (MDS), dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 6, indicating severe cognitive impairment. The MDS revealed Resident #1 required the physical assistance of staff with transfers, dressing, toileting, personal hygiene, and bathing. The MDS also revealed that Resident #1 received an anticoagulant (medication to thin the blood) on all seven days prior to the date of the MDS. Record review of Resident #1's Physician Telephone Orders revealed an order from Physician A, signed and dated on 04/28/16, that ordered a PT/INR every other Wed (Wednesday) AM. According to the U.S. National Library of Medicine a [MEDICATION NAME] time (PT) is a blood test that measures the time it takes for the liquid portion (plasma) of your blood to clot. PT is measured in seconds. Most of the time, results are given as what is called INR (international normalized ratio). If you are not taking blood thinning medicines, such as [MEDICATION NAME], the normal range for your PT results is . (an) INR of 0.8 to 1.1 If you are taking [MEDICATION NAME] to prevent blood clots, your doctor will most likely choose to keep your INR between 2.0 and 3.0. INR results higher than 3.0 may put you at even higher risk for bleeding. INR results lower than 2.0 may put you at risk for developing a blood clot. (https://medlineplus.gov/ency/article/ 2.htm-Accessed on 07/27/16) Record review of Resident #1's Order Recap Report, dated 06/20/16, revealed an order given by Physician A for [MEDICATION NAME] Tablet 10 MG (Milligram) ([MEDICATION NAME] Sodium) Give 1 tablet by mouth in the afternoon for anticoagulant. The order for [MEDICATION NAME] had a start date of 04/24/16 and order date of 04/23/16. According to the U.S. National Library of Medicine [MEDICATION NAME] ([MEDICATION NAME]) is a medication used to prevent blood clots from forming or growing larger in your blood and blood vessels. [MEDICATION NAME] is in a class of medications called anticoagulants ('blood thinners'). It works by decreasing the clotting ability of the blood. The U.S. National Library of Medicine also indicated if a person was prescribed [MEDICATION NAME] the doctor would order a blood test (PT ([MEDICATION NAME] test) reported as INR (international normalized ratio) value) regularly . to check . (the) body's response to [MEDICATION NAME]. (https://medlineplus.gov/druginfo/meds/ a 7.html-Accessed on 07/27/16) Record review of Resident #1's lab results from a local clinic, dated 04/29/16, revealed a PT/INR test was conducted on 04/29/16. The results were an INR of 2.83. Record review of Resident #1's lab results from a local clinic, dated 05/11/16, revealed on 05/11/16 at 1:30 AM the resident refused to have his blood drawn to conduct the scheduled PT/INR test. Additional documentation revealed Resident #1 refused another lab drawn on 05/12/16 at 1:22 AM. Record review of Resident #1's lab results from a local clinic revealed no further PT/INR test were performed or attempted from 05/13/16 until 06/20/16. Record review of Resident #1's nurses notes revealed the following entries: 06/19/16 1:36 PM Daughter in to see resident. Large bruise noted to left arm reaching from elbow to wrist. This nurse told daughter I would follow up and research lab draws and labs. Date of last lab draw 6/3/16 (lab unrelated to PT/INR test) . (Physician A) called and notified of resident status. Signed by LVN D. 06/19/16 6:04 PM MD called with order for STAT PT/INR. Signed by LVN D 06/20/16 7:35 AM Bruise remains to arm. Lab in facility to draw PT/INR without problems . Signed by LVN F 06/20/16 10:40 AM (Physician A) called and received new order for hold [MEDICATION NAME] today 06/20/16 and tomorrow 06/21/16 and d/c (discontinue) [MEDICATION NAME] 10 mg and restart [MEDICATION NAME] 8 mg daily (on 06/22/16). Resident and family notified. Signed by LVN B 06/20/16 11:16 AM Rec'd (received) critical labs of PT 63.4 and INR 6.46. Notified family and called (Physician A's) office . Signed by the DON Record review of Resident #1's Medication Administration Record, [REDACTED]. Record review of Resident #1's lab results from a local clinic, dated 06/20/16, revealed the following results from a PT/INR test conducted on 06/20/16: Test Name: INR Out of Range: 6.46 (H!)

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 0329 **Level of harm** - Actual harm **Residents Affected** - Some	(continued... from page 1) Reference Rang: .80-1.20 The lab results also revealed the results were identified as critical and called to the facility on 11:16 AM on 06/20/16. In an interview on 07/19/16 at 4:30 PM Physician A, Resident #1's physician, stated he had given orders 04/28/16 to monitor Resident#1's PT/INR levels every other Wednesday. He stated that due to the high dose of [MEDICATION NAME] Resident #1 was receiving and potential side effects that could occur to Resident #1, he was not comfortable checking this level every month. Physician A stated that he had only received two PT/INR levels regarding Resident #1 and they were dated 04/29/16 and 06/20/16. He did not have record of any refusals for attempts that the lab had made to draw a PT/INR on Resident #1 and also indicated that it was not appropriate to attempt a lab draw at 2:00 AM in the morning. Physician A stated the PT/INR test should have resumed every other Wednesday after the STAT PT/INR on 06/20/16. In an interview on 07/20/16 at 3:54 PM LVN D stated she was the nurse on duty on 06/19/16 when the daughter of Resident #1 brought to her attention the bruise on Resident #1's arm. LVN D stated that she knew he was on a large dose of [MEDICATION NAME] and could not find a recent PT/INR results, therefore she obtained an order for [REDACTED]. LVN D was not sure when the bruise on Resident #1's arm appeared but felt that Resident #1 could have bumped his arm anywhere and not reported to staff. LVN D stated that for any residents on [MEDICATION NAME] standing routine lab orders should be in place to monitor a residents PT/INR level and if there is not an order then the nurse on duty should obtain a clarification order via telephone with the physician. Based on the order given on 04/28/16 for Resident #1 to have a PT/INR test every other Wednesday, a PT/INR test should have been conducted on the following dates before the resident was discharged to the hospital on [DATE]: 05/11/16, 05/25/16, 06/08/16, 6/22/16, and 07/06/16. A PT/INR test was attempted on 05/11/16 and 05/12/16, but was not reattempted. A STAT PT/INR was conducted on 06/20/16. No PT/INR tests were attempted after the one conducted on 06/20/16. Record review of Resident #1's Medication Administration Record, [REDACTED]. Record review of Resident #1's Medication Administration Record, [REDACTED]. Record review of Resident #1's lab results from a local hospital, dated 07/14/16, revealed Resident's PT/INR levels were tested on [DATE] and his INR was 4.8, which was identified by the lab as critical. Record review of the pharmacy consultant's documentation for April 2016, May 2016, and June 2016 revealed no documentation related to Resident #1's [MEDICATION NAME] or PT/INR labs. Resident #2 Record review of Resident #2's Order Summary Report, dated 04/29/16, revealed he was a [AGE] year old male admitted to the facility on [DATE]. His [DIAGNOSES REDACTED]. Record review of Resident #2's Significant Change MDS, dated [DATE], revealed a BIMS score of 13, indicating he was cognitively intact. Resident #2's MDS indicated he required the physical assistance of staff for transfers, dressing, toileting, and personal hygiene. The MDS also revealed Resident #2 received an anticoagulant (medication to thin the blood) on all seven days prior to the date of the MDS. Record review of Resident #2's lab results from a local clinic, dated 03/21/16, revealed his PT/INR was tested on [DATE] and his INR was 1.38. Included on the lab results was a note handwritten by facility staff for his [MEDICATION NAME] to be increased from 7 MG daily to 8 MG every day and for his PT/INR to be checked every other Wednesday started 03/30/16. Record review of Resident #2's Physician Telephone Orders revealed an order, dated 03/24/16 and signed by Physician A, to change [MEDICATION NAME] to 8 mg PO (by mouth) Q (each) day and an order for [REDACTED]. Record review of Resident #2's lab results for a local clinic, dated 03/30/16, revealed his PT/INR was checked on 03/30/16. The lab results revealed Resident #2's INR was 2.62 and the reference range was .80-1.20. Included on the lab results was a note handwritten by facility staff that Resident #2's PT/INR levels were to be checked routinely every other Wednesday. Record review of Resident #2's lab results from a local clinic, dated 04/13/16, revealed his PT/INR was checked on 04/13/16. The lab results revealed Resident #2's INR was 4.63 and the reference range was .80-1.20. Included on the lab results was a note handwritten by facility staff that Resident #2's [MEDICATION NAME] was to be held on 04/14/16 and restarted at 7 MG daily on 04/15/16, and that Resident #2's PT/INR should be checked on a two week schedule routinely. Record review of Resident #2's lab results from a local clinic revealed no PT/INR test between 04/15/16 and 05/16/16. Based on Resident #2's physician order, dated 03/24/16, for Resident #2's PT/INR to be checked every other Wednesday Resident #2's PT/INR should have been checked on 04/27/16 and 05/11/16. Record review of Resident #2's lab results from a local clinic, dated 05/16/16, revealed his PT/INR level was tested on [DATE] at 1:50 AM and the results revealed the following: Test Name: INR Out of Range: 3.94 (High) Reference Rang: .80-1.20 Record review of Resident #2's clinical record revealed he was discharged to the hospital in June 2016 for issues unrelated to his [MEDICATION NAME] therapy. Record review of the pharmacy consultant's documentation for April 2016, May 2016, and June 2016 revealed no documentation related to Resident #2's [MEDICATION NAME] or PT/INR labs. Observation and interview with Resident #2 on 07/20/16 at 9:53 AM revealed no obvious signs of bruising visible to the surveyor. Resident #2 stated his skin is checked regularly. Resident #2 did not express any concerns related to bruising. Resident #3 Record review of Resident #3's Order Summary Report, dated 06/28/16, revealed he was a [AGE] year old male admitted to the facility on [DATE]. His [DIAGNOSES REDACTED]. Record review of Resident #3's Admission MDS, dated [DATE], revealed a BIMS of 3, which indicated sever cognitive impairment. The MDS revealed Resident #3 required the physical assistance of staff for transfers, locomotion, dressing, eating, toileting, personal hygiene, and bathing. The MDS also revealed Resident #3 received an anticoagulant (medication to thin the blood) on three days prior to the date of the MDS. Record review of Resident #3's Physician Telephone Order, dated 06/09/16 and signed by Physician A, revealed an order for [REDACTED]. Record review of Resident #3's lab results did not reveal a PT/INR test conducted on 06/10/15 as ordered on [DATE]. Record review of Resident #3's lab results from a local clinic, dated 06/15/16, revealed a PT/INR test was conducted on 06/15/16. The lab results revealed Resident #3's INR was 1.11 and with a reference range of .80-1.20. Hand written by facility staff on the lab results was a note that indicated Resident #3 was currently on 2 MG of [MEDICATION NAME] daily for [MEDICAL CONDITION] Fibrillation, and that is should be increased to 3 MG daily and the resident's PT/INR level checked every other Wednesday. Record review of Resident #3's Order Summery Report, dated 06/28/16 and signed by Physician A on 07/01/16, revealed the following orders: PT/INR Every Other Wednesday Start 6/29/16 (Order received date 06/16/16) and [MEDICATION NAME] Tablet ([MEDICATION NAME] Sodium) Give 3 mg by mouth in the evening for A-Fib ([MEDICAL CONDITION]) (Order date 06/16/16). Record review of Resident #3's lab results did not reveal any PT/INR test conducted between 06/29/16 and 07/20/16. Based on the order given on 06/16/16 Resident #3's PT/INR level should have been conducted on 06/29/16 and 07/13/16. Record review of Resident #3's Physician Orders, dated 07/20/16, revealed an order was given on 07/2016 for a STAT PT/INR. Record review of Resident #3's lab results for a local clinic, dated 07/21/16, revealed a PT/INR test was conducted on 07/21/16. The lab results indicated Resident #3's INR was 1.12 with a reference range of .80-1.20. Hand written by facility staff was a note on the lab results that Physician A was contacted with the results on 07/21/16 and ordered Resident #3's [MEDICATION NAME] increased to 3.5 MG daily. Record review of the pharmacy consultant's documentation for April 2016, May 2016, and June 2016 revealed no documentation related to Resident #3's [MEDICATION NAME] or PT/INR labs. Observation and interview with Resident #3 on 07/21/16 at 11:53 AM revealed no obvious signs of significant bruising visible to the surveyor. Resident #3 did have a bruise on the large toe of his left foot, but it was unrelated to his [MEDICATION NAME] therapy. Resident #3 did not express any concerns related to bruising. Resident #4 Record review of Resident #4's Admission Record, dated 07/21/16, revealed he was a [AGE] year old male admitted to the facility on [DATE]. His [DIAGNOSES REDACTED]. Record review of Resident #4's Quarterly MDS, dated [DATE], revealed a BIMS score of 9, which indicated moderate cognitive

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F 0329 **Level of harm -** Actual harm **Residents Affected -** Some	(continued... from page 2) impairment. The MDS revealed Resident #4 required the physical assistance of staff for transfers, locomotion, dressing, toileting personal hygiene, and bathing. The MDS also revealed Resident #4 received an anticoagulant (medication to thin the blood) on all seven days prior to the date of the MDS. Record review of Resident #4's discharge orders from a local hospital, dated 05/31/16, revealed Resident #4 was discharged from the hospital back to the facility with the following order: [MEDICATION NAME] 4 mg oral tablet 1 tab(s) orally once a day START when INR is below 2.0. The DON signed on the discharge orders that they were noted on 06/01/16. Record review of Resident #4's Order Summary Report, dated 06/01/16, revealed an order dated 06/01/16 for a one time PT/INR test on 06/02/16. Record review of Resident #4's lab results revealed no PT/INR test was conducted on 06/02/16. Further review revealed the first PT/INR test conducted after the resident's return to the facility on [DATE] was on 06/15/16. Review of the PT/INR conducted on 06/15/16 revealed Resident #4's INR was 1.72. In an interview on 07/21/16 at 4:02 PM the Nurse Consultant stated the lab reported the only PT/INR test conducted on Resident #4 were on 06/15/16 and 07/21/16. Record review of Resident #4's Medication Administration Record [REDACTED]. Record review of the pharmacy consultant's documentation for April 2016, May 2016, and June 2016 revealed no documentation related to Resident #4's [MEDICATION NAME] or PT/INR labs. In an interview on 07/20/16 at 2:03 PM with the DON, she stated that the facility did not have a policy in regards to anticoagulant therapy. In an interview on 07/20/16 at 4:05 PM the DON stated that her expectation when a resident was on a blood thinner, especially [MEDICATION NAME], that there be an order for [REDACTED]. The DON stated once the lab received the order the facility relied on the lab to ensure routine labs were conducted as scheduled. The DON stated her expectation would be for the nurses to adhere to the orders given by the physician for lab work and that if a resident refused or a lab was missed the doctor would be notified for each occurrence. She stated that the tracking of labs was done using the lab book that was kept at the nurse's station. The DON stated the lab personnel either provided a print out from the lab company of all the residents who had labs drawn on the day the lab came in or lab personnel completed a sheet specific to resident if it is not a routine lab. The DON stated these forms are what were in the lab book. The DON stated this was also where it is documented if a resident refused a lab. She stated she was unaware that the labs were being drawn between the hours of 1:30 AM and 3:00 AM and indicated that that was ridiculous and her expectation would be around 5:00AM at the earliest for a resident to receive a blood draw. The DON did say that her expectation when a resident refused a lab draw would be for the nurse on duty to notify the physician and that a reasonable attempt should be made to try and obtain the lab work again. She did not feel that a reasonable attempt would be at the same time the next day at 2:00 AM with a resident who was cognitively impaired. Record review of the facility's Order Listing Report for Anti-Coagulants, dated 07/20/16, revealed seven residents were prescribed [MEDICATION NAME].