STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676179	A. BUILDING _____ B. WING _____	04/16/2018

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SENIOR CARE OF MIDLAND	3000 MOCKINGBIRD LN MIDLAND, TX 79705

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 0755 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	**Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident for one (Resident #1) of 9 residents reviewed for pharmacy services. - The facility failed to transcribe Resident #1's Xarelto (anticoagulant medication) to the computer printout Medication Administration Record (MAR) which lead to the resident not receiving the medication from 01/28/18 through 04/05/18. Resident #1 was hosptalized on [DATE] and found to have a [MEDICAL CONDITION] Embolism (PE) and a [MEDICAL CONDITIONS]. - This was determined to be past non-compliance due to the facility having implemented action that corrected the non-compliance prior to the beginning of the investigation. These failures could affect 24 residents on an anticoagulant, placing them at risk for not receiving therapeutic doses of their medications and an increased risk of developing blood clots leading to possible embolism, [MEDICAL CONDITION] and/or death. Findings Included: Record review of Resident #1's face sheet dated 04/05/18 indicated he was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. He was [AGE] years of age. Record review of Resident #1's physician orders [REDACTED]. - Xarelto 20mg tablet 1 tab PO with evening meal. Anticoagulant. Generic: Rivaroxaban. Order date 09/02/17. (mg = milligrams, PO=by mouth). According to their web-site, Xarelto is a prescription medicine used to reduce the risk of stroke and blood clots in people with [MEDICAL CONDITION], not caused by a heart valve problem. https://www.xarelto-us.com/about-xarelto/how-xarelto-works. Accessed on 04/20/18. Record review of Resident #1's Minimum Data Set (MDS) assessment dated [DATE] indicated in part: - Brief Interview Mental Status (BIMS) = 10. (8-12 moderately impaired). - Active [DIAGNOSES REDACTED]. Record review of Resident #1's Care Plan dated 10/10/17 indicated in part: - Problem/Need. Problem onset: 09/02/17. [MEDICAL CONDITIONS] - Resident takes anticoagulant. - Goal and target date: The [MEDICAL CONDITION] will dissolved within 30 days. - Approaches. Administer anticoagulants as ordered. Record review of Resident #1's facility admission orders [REDACTED] - Rivaroxaban 20mg PO qday (every day). Note: Resident was admitted to the hospital on [DATE] and returned to the facility on [DATE]. Record review of Resident #1's MARs for (MONTH) (YEAR), (MONTH) (YEAR), (MONTH) (YEAR) and (MONTH) (YEAR) did not have Xarelto as one of the medications to be administered as ordered for a total of 67 missed doses. Record review of Resident #1's physician orders [REDACTED]. Record review of Resident #1's nurses notes indicated in part: - 0630 (6:30 a.m.) 04/05/18. When making rounds this morning Pt (patient) stated his right lower quad was hurting. Pain medication given [MEDICATION NAME]. @ 0645 (6:45 a.m.) Pt stated the pain had gotten worst V/S (vital signs) taken - Pt having SOB (shortness of breath) and was not able to breathe. Pt sent to local hospital to be evaluated. Record review of Resident #1's hospital records dated 04/05/18 indicated in part: - admitted : 04/05/18. Chief complaint abdominal pain. History of present illness. This morning he developed sudden onset of right upper quadrant pain that he described as 8 on a 0 to 10 scale. He also complained of right thigh pain. While in the emergency department a CT scan of the abdomen and pelvis with contrast was obtained with the following radiologist impression: Incidental [MEDICAL CONDITION] embolism with involvement of at least the right lower lobe. He was started on [MEDICATION NAME] for [MEDICAL CONDITION] protocol and hospitalist service was consulted to admit the patient. (CT=computed tomography) - Assessment 1. Acute [MEDICAL CONDITION] secondary PE. 2. [MEDICAL CONDITION] Embolism (PE). 5. [MEDICAL CONDITION] left lower extremity. A [MEDICAL CONDITION] embolism is a blockage in one of the [MEDICAL CONDITION] arteries in your lungs. In most cases, [MEDICAL CONDITION] embolism is caused by blood clots that travel to the lungs from the legs or, rarely, other parts of the body ([MEDICAL CONDITION]. https://www.mayoclinic.org/diseases-conditions/pulmonary-embolism/symptoms-causes/syc- 647 Sources accessed on 04/25/18. [MEDICAL CONDITIONS] occurs when a blood clot (thrombus) forms in one or more of the deep veins in your body, usually in your legs. [MEDICAL CONDITION] can cause leg pain or swelling, but also can occur with no symptoms. https://www.mayoclinic.org/diseases-conditions/deep-vein-[MEDICAL CONDITION]/symptoms-causes/syc- 557 Sources accessed on 04/25/18. - PLAN: 1. We will admit the patient to the post-critical care unit with telemetry. 2. Regarding acute [MEDICAL CONDITION]: we will go ahead and treat for PE and early pneumonia. 3. Regarding [MEDICAL CONDITION] embolism: The patient was started on [MEDICAL CONDITION]. 5. Regarding [MEDICAL CONDITION]: [MEDICATION NAME] protocol. During an interview on 04/11/18 at 1:55 p.m. the Director of Nurses (DON) said Resident #1 had not received his Xarelto/Rivaroxaban medication from 01/28/18 through 04/05/18 due to it not being transcribed to the new (MONTH) (YEAR) MAR. The DON said according to the written admission order for (MONTH) (YEAR) it indicated Resident #1 received the Xarelto/Rivaroxaban on the 26th and 27th but after that it was dropped due to the new print out MAR no longer having the Xarelto/Rivaroxaban order on it. During an interview on 04/12/18 at 10:16 a.m. Medication Aide (MA) A said she was the medical records person. MA A said she would transcribe the written admission orders [REDACTED]=Treatment Administration Record). MA A said after she printed the MAR/TAR she would then go and place them in the medication aide's MARs book or the nurses TARs book. MA A said she would tell the MA or nurse to check the MAR/TAR and make sure it was correct after placing it in the MAR or TAR book. MA A said she was the one who had transcribed Resident #1's admission orders [REDACTED]. MA A said that she left out the medication Xarelto/Rivaroxaban when she did the transcription. MA A said sometimes she gets distracted while conducting the transcription and could have caused her to make that error. MA A said she acknowledged she had made an error. MA A said from now on once she transcribed the new orders and printed out the new MARs/TARs she would hand the printouts to the

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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SENIOR CARE OF MIDLAND	**3000 MOCKINGBIRD LN MIDLAND, TX 79705**

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F 0755 **Level of harm** - Immediate jeopardy **Residents Affected** - Some	(continued... from page 1) ADON/nurse to review it before being placed in the MARs/TARs book. (ADON = Assistant Director of Nurses) During an interview on 04/12/18 at 10:52 a.m. Resident #1 said he had gone to the hospital because he had developed a blood clot. Resident #1 said last week he had a lot of pain in his abdomen and had been transferred to the hospital and that was where it was determined he had a blood clot. During an interview on 04/12/18 at 12:12 p.m. MA B said it was her initials on Resident #1's admission orders [REDACTED]. MA B said the initials indicated she had administered Resident #1 his Xarelto/Rivaroxaban. MA B said she did not recall if she had obtained the medication from the resident's blister pack or had asked the nurse to pull it from the emergency kit. MA B said it was hard to notice that the resident's Xarelto/Rivaroxaban had been left out since the new MAR did not have that order on it anymore. During an interview on 04/13/18 at 11:59 a.m. the DON said after they had conducted the 100% audit of all the resident's orders on 04/05/18 and there had not been any other errors found. Record review of the facility's policy titled Medication orders dated 2001 indicated in part: - The purpose of this procedure is to establish uniform guidelines in the receiving and recording of medication orders. - A current list of orders must be maintained in the clinical record of each resident. - Recording Orders. Medication orders - when recording orders for medications, specify the type, route, dosage, frequency and strength of the medication ordered. - Medication shall be administered only upon the written order of a person duly licensed and authorized to prescribe such medications in this state. It was determined these failures placed Resident #1 in an Immediate Jeopardy situation which continued from 01/28/18 to 04/05/18. The facility took the following action to correct the non-compliance: Review of the provider investigative report dated 04/05/18 indicated in part: - Family and physician were notified and patient sent to emergency room . Provider response when family reported Xarelto not given since readmission was as follows. 1) Immediate review of last 10 admissions for accuracy of transcription to MAR to computer order entry. 2) 100% audit of resident's physician orders [REDACTED]. 3) Head to toe skin assessments were completed on all residents receiving anticoagulants to check for any signs of redness, warmth, pain or tenderness. Record review of the facility' performance improvement plan dated 04/05/18. Observation: Order transcription. Goal/objective: To reduce the risk of order transcription errors. Actions: 1. Physician orders [REDACTED]. The 2nd nurse will review the physician orders [REDACTED]. The 2nd nurse will also verify that the medication has been ordered from the pharmacy and or the lab/x-ray has been ordered through the provider of service and that there is a notation on the 24 hour report book. The 2nd nurse will then cosign the order. In the event there is only one nurse on duty-the charge nurse will ask the oncoming nurse to review and co-sign. Responsible party: Chg nurse. (Chg = charge) Date completed: 4/5/18. Actions: 2. All new orders will be reviewed daily during clinical team to verify transcription accuracy, documentation on the 24 hour report, and follow through of order to completion. Any outstanding actions items related to new orders will be placed on the white board/flip chart to review until resolved. Responsible party: Adm/DON. (Adm = Administrator). Date completed: 4/5/18. Actions: 3. An afternoon stand down meeting will be held daily to review all items listed on white board/flip chart/daily clinical minutes - items will be erased/lined through when completed. Responsible party: DON. Date completed: 4/5/18. Actions: 4. Charge nurses will report to daily clinical and stand down meetings. They will bring their 24 hour report, all physician orders, incident reports, and x-ray/lab reports. They should report to meeting one at a time and not be in meeting more than 7-8 minutes. Responsible party: Chg nurse. Date completed: 4/5/18. Actions: 5. Nurse Management team will be in-serviced regarding process and expectations of follow up. Responsible party: DON. Date completed: 4/5/18. Actions: 6. Charge nurses will be in-serviced on new process now and as a part of new hire orientation. Responsible party: DON/Nurse managers. Date completed: 4/5/18. Record review of the facility's census list dated 04/05/18 indicated all physician orders [REDACTED]. (Note: this document was part of the 100% audit conducted by the facility). Record review of the facility's detail admission/Discharge report dated 04/05/18 indicated admit orders to med reconciled to MARS, printed checked and verified for accuracy. (Note: this document was part of the 100% audit conducted by the facility). Record on in-service dated 04/05/18 indicated in part: Admission/re-admission - all new orders from hospital will be checked to orders written for accuracy 2 nurses will sign off on transcription to validate accuracy, the 2nd nurse will also make sure /confirm meds have been ordered from Rx (pharmacy) and will note on 24H report book. (also ensure any labs required are completed filled out). - When MARS are printed it will be reviewed by a nurse for accuracy before placing in MAR book. - End of month reconciliation will review chart orders and MARS for any changes and note to ensure accuracy. - Night nurse will verify the orders and verify against MAR. - When transcribing new order on MAR initial date and write Dx (diagnosis) nurse that verifies order on MAR will also initial. Separate interviews were conducted with MA A on 04/12/18 at 10:16 a.m., RN C on 04/12/18 at 4:12 p.m., Licensed Vocational Nurse (LVN) D on 04/13/18 at 12:25 p.m., ADON E on 04/16/18 at 2:12 p.m., and LVN F on 04/16/18 at 3:40 p.m. Each staff member responded correctly to the following questions: What is the new process for transcribing new physician orders [REDACTED]. If it's a new telephone physician order [REDACTED]. The new physician order [REDACTED]. The night nurse will then check that order again and verify by looking in the MAR and initialing it. The new orders will be given to medical records who will then transcribe into the computer printout MAR. The medical records person will then printout the new MAR and have the ADON/charge nurse to check for verification before being placed in the MAR. The nurses from now on will be administering all the anticoagulant medications. Record review of the facility census report dated 04/16/18 provided by the DON indicated there were 24 residents in the facility that were on an anticoagulant medication.
F 0760 **Level of harm** - Immediate jeopardy **Residents Affected** - Some	**Ensure that residents are free from significant medication errors.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure residents were free of significant medication errors for one (Resident #1) of nine residents reviewed for medication errors. - The facility failed to transcribe Resident #1's Xarelto (anticoagulant medication) to the computer printout Medication Administration Record (MAR) which lead to the resident not receiving the medication from 01/28/18 through 04/05/18. Resident #1 was hosptalized on [DATE] and found to have a [MEDICAL CONDITION] Embolism (PE) and a [MEDICAL CONDITIONS]. - This was determined to be past non-compliance due to the facility having implemented action that corrected the non-compliance prior to the beginning of the investigation. These failures could affect 24 residents on an anticoagulant, placing them at risk for not receiving therapeutic doses of their medications and an increased risk of developing blood clots leading to possible embolism, [MEDICAL CONDITION] and/or death. Findings Included: Record review of Resident #1's face sheet dated 04/05/18 indicated he was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. He was [AGE] years of age. Record review of Resident #1's physician orders [REDACTED].

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F 0760 **Level of harm** - Immediate jeopardy **Residents Affected** - Some	(continued... from page 2) - Xarelto 20mg tablet 1 tab PO with evening meal. Anticoagulant. Generic: Rivaroxaban. Order date 09/02/17. (mg = milligrams, PO=by mouth). According to their web-site, Xarelto is a prescription medicine used to reduce the risk of stroke and blood clots in people with [MEDICAL CONDITION], not caused by a heart valve problem. https://www.xarelto-us.com/about-xarelto/how-xarelto-works. Accessed on 04/20/18. Record review of Resident #1's Minimum Data Set (MDS) assessment dated [DATE] indicated in part: - Brief Interview Mental Status (BIMS) = 10. (8-12 moderately impaired). - Active [DIAGNOSES REDACTED]. Record review of Resident #1's Care Plan dated 10/10/17 indicated in part: - Problem/Need. Problem onset: 09/02/17. [MEDICAL CONDITIONS] - Resident takes anticoagulant. - Goal and target date: The [MEDICAL CONDITION] will dissolved within 30 days. - Approaches. Administer anticoagulants as ordered. Record review of Resident #1's facility admission orders [REDACTED] - Rivaroxaban 20mg PO qday (every day). Note: Resident was admitted to the hospital on [DATE] and returned to the facility on [DATE]. Record review of Resident #1's MARs for (MONTH) (YEAR), (MONTH) (YEAR), (MONTH) (YEAR) and (MONTH) (YEAR) did not have Xarelto as one of the medications to be administered as ordered for a total of 67 missed doses. Record review of Resident #1's physician orders [REDACTED]. Record review of Resident #1's nurses notes indicated in part: - 0630 (6:30 a.m.) 04/05/18. When making rounds this morning Pt (patient) stated his right lower quad was hurting. Pain medication given [MEDICATION NAME]. @ 0645 (6:45 a.m.) Pt stated the pain had gotten worst V/S (vital signs) taken - Pt having SOB (shortness of breath) and was not able to breathe. Pt sent to local hospital to be evaluated. Record review of Resident #1's hospital records dated 04/05/18 indicated in part: - admitted : 04/05/18. Chief complaint abdominal pain. History of present illness. This morning he developed sudden onset of right upper quadrant pain that he described as 8 on a 0 to 10 scale. He also complained of right thigh pain. While in the emergency department a CT scan of the abdomen and pelvis with contrast was obtained with the following radiologist impression: Incidental [MEDICAL CONDITION] embolism with involvement of at least the right lower lobe. He was started on [MEDICATION NAME] for [MEDICAL CONDITION] protocol and hospitalist service was consulted to admit the patient. (CT=computed tomography) - Assessment 1. Acute [MEDICAL CONDITION] secondary PE. 2. [MEDICAL CONDITION] Embolism (PE). 5. [MEDICAL CONDITION] left lower extremity. A [MEDICAL CONDITION] embolism is a blockage in one of the [MEDICAL CONDITION] arteries in your lungs. In most cases, [MEDICAL CONDITION] embolism is caused by blood clots that travel to the lungs from the legs or, rarely, other parts of the body ([MEDICAL CONDITION]. https://www.mayoclinic.org/diseases-conditions/pulmonary-embolism/symptoms-causes/syc- 647 Sources accessed on 04/25/18. A [MEDICAL CONDITIONS] occurs when a blood clot (thrombus) forms in one or more of the deep veins in your body, usually in your legs. [MEDICAL CONDITION] can cause leg pain or swelling, but also can occur with no symptoms. https://www.mayoclinic.org/diseases-conditions/deep-vein-[MEDICAL CONDITION]/symptoms-causes/syc- 557 Sources accessed on 04/25/18. - PLAN: 1. We will admit the patient to the post-critical care unit with telemetry. 2. Regarding acute [MEDICAL CONDITION]: we will go ahead and treat for PE and early pneumonia. 3. Regarding [MEDICAL CONDITION] embolism: The patient was started on [MEDICAL CONDITION]. 5. Regarding [MEDICAL CONDITION]: [MEDICATION NAME] protocol. During an interview on 04/11/18 at 1:55 p.m. the Director of Nurses (DON) said Resident #1 had not received his Xarelto/Rivaroxaban medication from 01/28/18 through 04/05/18 due to it not being transcribed to the new (MONTH) (YEAR) MAR. The DON said according to the written admission order for (MONTH) (YEAR) it indicated Resident #1 received the Xarelto/Rivaroxaban on the 26th and 27th but after that it was dropped due to the new print out MAR no longer having the Xarelto/Rivaroxaban order on it. During an interview on 04/12/18 at 10:16 a.m. Medication Aide (MA) A said she was the medical records person. MA A said she would transcribe the written admission orders [REDACTED]=Treatment Administration Record). MA A said after she printed the MAR/TAR she would then go and place them in the medication aide's MARs book or the nurses TARs book. MA A said she would tell the MA or nurse to check the MAR/TAR and make sure it was correct after placing it in the MAR or TAR book. MA A said she was the one who had transcribed Resident #1's admission orders [REDACTED]. MA A said that she left out the medication Xarelto/Rivaroxaban when she did the transcription. MA A said sometimes she gets distracted while conducting the transcription and could have caused her to make that error. MA A said she acknowledged she had made an error. MA A said from now on once she transcribed the new orders and printed out the new MARs/TARs she would hand the printouts to the ADON/nurse to review it before being placed in the MARs/TARs book. (ADON = Assistant Director of Nurses) During an interview on 04/12/18 at 10:52 a.m. Resident #1 said he had gone to the hospital because he had developed a blood clot. Resident #1 said last week he had a lot of pain in his abdomen and had been transferred to the hospital and that was where it was determined he had a blood clot. During an interview on 04/12/18 at 12:12 p.m. MA B said it was her initials on Resident #1's admission orders [REDACTED]. MA B said the initials indicated she had administered Resident #1 his Xarelto/Rivaroxaban. MA B said she did not recall if she had obtained the medication from the resident's blister pack or had asked the nurse to pull it from the emergency kit. MA B said it was hard to notice that the resident's Xarelto/Rivaroxaban had been left out since the new MAR did not have that order on it anymore. During an interview on 04/13/18 at 11:59 a.m. the DON said after they had conducted the 100% audit of all the resident's orders on 04/05/18 and there had not been any other errors found. Record review of the facility's policy titled Medication orders dated 2001 indicated in part: - The purpose of this procedure is to establish uniform guidelines in the receiving and recording of medication orders. - A current list of orders must be maintained in the clinical record of each resident. - Recording Orders. Medication orders - when recording orders for medications, specify the type, route, dosage, frequency and strength of the medication ordered. - Medication shall be administered only upon the written order of a person duly licensed and authorized to prescribe such medications in this state. It was determined these failures placed Resident #1 in an Immediate Jeopardy situation which continued from 01/28/18 to 04/05/18. The facility took the following action to correct the non-compliance: Review of the provider investigative report dated 04/05/18 indicated in part: - Family and physician were notified and patient sent to emergency room . Provider response when family reported Xarelto not given since readmission was as follows. 1) Immediate review of last 10 admissions for accuracy of transcription to MAR to computer order entry. 2) 100% audit of resident's physician orders [REDACTED]. 3) Head to toe skin assessments were completed on all residents receiving anticoagulants to check for any signs of redness, warmth, pain or tenderness. Record review of the facility' performance improvement plan dated 04/05/18. Observation: Order transcription. Goal/objective: To reduce the risk of order transcription errors. Actions: 1. Physician orders [REDACTED]. The 2nd nurse will review the physician orders [REDACTED]. The 2nd nurse will also verify that the medication has been ordered from the pharmacy and or the lab/x-ray has been ordered through the provider of service and that there is a notation on the 24 hour report book. The 2nd nurse will then cosign the order. In the event there is only one nurse on duty-the charge nurse will ask the oncoming nurse to review and co-sign. Responsible party: Chg nurse. (Chg = charge) Date completed: 4/5/18. Actions: 2. All new orders will be reviewed daily during clinical team to verify transcription accuracy, documentation on the 24 hour report, and follow through of order to completion. Any outstanding actions items related to new orders will be placed on the white board/flip chart to review until resolved. Responsible party: Adm/DON. (Adm = Administrator).

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F 0760 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 3) Date completed: 4/5/18. Actions: 3. An afternoon stand down meeting will be held daily to review all items listed on white board/flip chart/daily clinical minutes - items will be erased/lined through when completed. Responsible party: DON. Date completed: 4/5/18. Actions: 4. Charge nurses will report to daily clinical and stand down meetings. They will bring their 24 hour report, all physician orders, incident reports, and x-ray/lab reports. They should report to meeting one at a time and not be in meeting more than 7-8 minutes. Responsible party: Chg nurse. Date completed: 4/5/18. Actions: 5. Nurse Management team will be in-serviced regarding process and expectations of follow up. Responsible party: DON. Date completed: 4/5/18. Actions: 6. Charge nurses will be in-serviced on new process now and as a part of new hire orientation. Responsible party: DON/Nurse managers. Date completed: 4/5/18. Record review of the facility's census list dated 04/05/18 indicated all physician orders [REDACTED]. (Note: this document was part of the 100% audit conducted by the facility). Record review of the facility's detail admission/Discharge report dated 04/05/18 indicated admit orders to med reconciled to MARS, printed checked and verified for accuracy. (Note: this document was part of the 100% audit conducted by the facility). Record on in-service dated 04/05/18 indicated in part: Admission/re-admission - all new orders from hospital will be checked to orders written for accuracy 2 nurses will sign off on transcription to validate accuracy, the 2nd nurse will also make sure /confirm meds have been ordered from Rx (pharmacy) and will note on 24H report book. (also ensure any labs required are completed filled out). - When MARS are printed it will be reviewed by a nurse for accuracy before placing in MAR book. - End of month reconciliation will review chart orders and MARS for any changes and note to ensure accuracy. - Night nurse will verify the orders and verify against MAR. - When transcribing new order on MAR initial date and write Dx (diagnosis) nurse that verifies order on MAR will also initial. Separate interviews were conducted with MA A on 04/12/18 at 10:16 a.m., RN C on 04/12/18 at 4:12 p.m., Licensed Vocational Nurse (LVN) D on 04/13/18 at 12:25 p.m., ADON E on 04/16/18 at 2:12 p.m., and LVN F on 04/16/18 at 3:40 p.m. Each staff member responded correctly to the following questions: What is the new process for transcribing new physician orders [REDACTED]. If it's a new telephone physician order [REDACTED]. The new physician order [REDACTED]. The night nurse will then check that order again and verify by looking in the MAR and initialing it. The new orders will be given to medical records who will then transcribe into the computer printout MAR. The medical records person will then printout the new MAR and have the ADON/charge nurse to check for verification before being placed in the MAR. The nurses from now on will be administering all the anticoagulant medications. Record review of the facility census report dated 04/16/18 provided by the DON indicated there were 24 residents in the facility that were on an anticoagulant medication.