STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155377	A. BUILDING 00 B. WING	02/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SEYMOUR CROSSING	707 S JACKSON PARK DR SEYMOUR, IN 47274

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates: Feburary 20, 21, 24, 25, and 26, 2025. Facility number: 000272 Provider number: 155377 AIM number: 100274710 Census Bed Type: SNF/NF: 77 Total: 77 Census Payor Type: Medicare: 1 Medicaid: 55 Other: 21 Total: 77 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on March 5, 2025.	F 0000	This Plan of Correction constitutes the facility's written allegation of compliance for the deficiencies cited. This submission of this Plan of Correction is not an admission of or agreement with the deficiencies or conclusions contained in the Department's inspection report. We respectfully request a desk review and ask that your office accept this plan as our facility's compliance. Please feel free to contact Jay Myers, Executive Director, should you need any additional information to support the desk review at 812-522-2416. Thank you for your consideration.	
F 0684 SS=D Bldg. 00	483.25 Quality of Care Based on record review, interview, and observation, the facility failed to follow the physician's medication hold parameters for residents' cardiac medication administration and failed to follow the treatment orders for a resident's nephrostomy tube for 3 of 20 residents reviewed for Quality of Care. (Residents 18, 70, and 38) Findings include:	F 0684	**F 684 Quality of Care** **1)** **What corrective action will be accomplished for those residents found to have been affected by the deficient practic e?** Resident #18's EMARs were reviewed on ___3/10/25____ at which time physician was	03/24/2025

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

Jay Myers | HFA | 03/17/2025

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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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	1. The clinical record for Resident 18 was reviewed on 02/26/25 at 1:30 P.M. An Annual Minimum Data Set (MDS) assessment, dated 12/26/24, indicated the resident was cognitively intact. The resident's diagnoses included, but were not limited to, atrial fibrillation, hypertension, heart failure, and renal insufficiency. The resident received dialysis treatments. The resident's current physician's orders included an open-ended order, with a start date of 01/20/25, to administer midodrine (a medication for low blood pressure) 5 mg (milligrams) every 6 hours as needed for a systolic (the top number) blood pressure less than 110. The resident's vital signs record and Electronic Medication Administration Record (EMAR) for January and February 2025 indicated the resident did not receive the midodrine medication when their blood pressure was assessed and below 110 on the following dates and times: - On 01/24/25 at 1:00 P.M., the resident's blood pressure was 101/69, - On 01/27/25 at 12:07 P.M., the resident's blood pressure was 106/63, - On 01/29/25 at 12:08 P.M., the resident's blood pressure was 105/64, - On 02/01/25 at 5:41 A.M., the resident's blood pressure was 106/71, - On 02/09/25 at 7:22 A.M., the resident's blood pressure was 86/51, - On 02/12/25 at 11:42 A.M., the resident's blood pressure was 103/84, and - On 02/16/25 at 6:39 A.M., the resident's blood pressure was 92/51. During an interview, on 02/26/25 at 1:37 P.M., the		contacted and notified of Midodrine not being given per special instructions on 01/24/25, 1/27/25, 1/29/25, 2/1/25, 2/9/25, 2/12/25, and 2/16/25. No new orders were received Resident #70's EMARs were reviewed on ___3/10/25____ at which time physician was contacted and notified of Lisinopril-Hydrochlorothiazide being given outside hold parameter orders on 12/27/24, 12/28/24, 12/30/24, 1/2/25, 1/3/25, 1/9/25, and 1/12/25. No new orders were received. Resident #38's EMAR and Nephrostomy tube orders were reviewed on ___3/10/25____ at which time the physician was contacted and notified of dressing change order not being followed. No new orders were received. **2)** **How other residents having the potential to be affected by t he same deficient practice will be identified and what corrective action(s) will be taken.** All residents having hold parameters related to their blood pressure medication and nephrostomy tubes have the potential to be affected by the alleged deficient practice. A hold parameters audit was completed on all resident who have hold parameters for the last 30 days to ensure they were	

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	resident indicated nursing staff checked his blood pressure a lot. His blood pressure was sometimes low after dialysis. He had an order for midodrine that was fairly new. He had only received the medication a few times. During an interview, on 02/26/25 at 2:11 P.M., the Infection Preventionist (IP) RN indicated if the resident's blood pressure was assessed and it was below 110, the medication should have been administered according to the MD order. 2. The clinical record for Resident 70 was reviewed on 02/24/25 at 2:27 P.M. A Significant Change MDS assessment, dated 01/16/25, indicated the resident was cognitively intact. The resident's diagnoses included, but were not limited to, hypertension and cerebral palsy. A physician's order, dated 12/26/24 through 02/25/25, indicated the staff were to administer Lisinopril-Hydrochlorothiazide 10-12.5 mg. The staff were to hold the medication if the resident's systolic blood pressure was less than 130. The December 2024 and January 2025 EMAR/ETAR indicated the resident received the medication when their systolic blood pressure was less than 130 for the following dates and times: - On 12/27/24, when the resident's blood pressure was 122/71, - On 12/28/24, when the resident's blood pressure was 118/65, - On 12/30/24, when the resident's blood pressure was 118/72, - On 01/02/25, when the resident's blood pressure was 96/67, - On 01/03/25, when the resident's blood pressure was 123/73,		followed. A nephrostomy care audit was completed on all resident who have Nephrostomy tubes to ensure dressing changes are occurring as order/per facility policy. **3)** **What measures will be put into place or what systemic changes will be made to ensur e** **that the deficient practice does not recur?** The DNS/designee in-serviced facility nurses on following physicians orders related to hold parameters for blood pressure medication and on Nephrostomy Care skills validation. The DNS/designee will review blood pressure medications with hold parameters daily during the clinical meeting to ensure MD orders are followed. The DNS/designee will completed a review of the nephrostomy care during wound rounds per MD order. **4)** **How the corrective action(s) will be monitored to ensure the** **deficient practice will not recur , i.e. what quality assurance program will be put into place?** **.** To ensure compliance the DNS/designee will complete blood pressure medication reviews if they include hold parameters &	

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	- On 01/09/25, when the resident's blood pressure was 122/69, and - On 01/12/25, when the resident's blood pressure was 126/63. During an interview, on 02/26/25 at 1:53 P.M., LPN 3 indicated if a resident had hold parameters on their medications, then she would obtain the vital signs prior to administering the medications and if it was outside the parameter she would not give the medication. She would document in the EMAR that the medication was held. The current facility policy titled, "General Dose Preparation and Medication Administration", dated 11/15/24, was provided by the DON on 02/26/25 at 1:37 P.M. The policy indicated, "...Verify each time a medication is administered that it is the correct medication, at the correct dose, at the correct route, at the correct rate, at the correct time, for the correct resident...If necessary, obtain vital signs..." 3. During an observation on 02/26/25 at 9:24 A.M., the IP prepared a clean space for supplies in the resident's room to cleanse Resident 38's nephrostomy tubes (tubes placed in the back to drain urine from the kidneys). The IP cleansed around both nephrostomy tube insertion sites (left and right side) with normal saline soaked swabs and cleansed the skin surrounding the sites, where the old bandage was removed, with wound cleanser. An open-ended physician's order, with a start date of 02/13/25, indicated the staff were to cleanse around the nephrostomy tubes with warm soap and water, rinse, gently pat dry, and apply a split boarder gauze around the nephrostomy tubes.		wound & skin CQI audit tool, weekly x 4 weeks, then monthly x 6 months, and quarterly thereafter. CQI committee will determine need for further review. The results of these audits will be reviewed by the CQI Committee, if threshold of 100% is not achieved an action plan will be completed. Deficiency in this practice will result in disciplinary action up to and including termination. **5) Completion Date 3/24/25**	

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	During an interview, on 02/26/25 at 10:00 A.M., the IP indicated the resident's order was to cleanse around the tubes with soap and water. She had used normal saline because that was what their policy said. She should have followed the orders of the physician and cleansed around the tubes with soap and water. The current facility policy titled, "Nephrostomy Tube Care Dressing Change, Drainage Bag Change & Irrigation" with a review date of 12/2012, was provided by the IP on 02/26/25 at 10:43 A.M. The policy indicated, "...Verify resident and physician orders..." During an interview, on 02/26/25 at 1:56 P.M., the Regional Support indicated they did not have a policy on following physician orders. It was just standard practice. 3.1-37(a)			
F 0692 SS=D Bldg. 00	483.25(g)(1)-(3) Nutrition/Hydration Status Maintenance Based on record review and interview, the facility failed to document meal consumptions for 2 of 4 residents reviewed for nutrition. (Residents 16 and 36) Findings include: 1. The clinical record for Resident 16 was reviewed on 02/24/25 at 10:13 A.M. A Significant Change Minimum Data Set (MDS) assessment, dated 01/31/25, indicated the resident was severely cognitively impaired. The resident's diagnoses included, but were not limited to, hypertension, diabetes, non-Alzheimer's dementia, anxiety, and	F 0692	**F 692 Nutrition/Hydration Status Maintenance** **1)** **What corrective action will be accomplished for those residents found to have been affected by the deficient practic e?** Resident #16's physician was contacted and notified of missed meal consumption 1/10/25, 1/11/25, 1/15/25, 1/17/25, 1/22/25, 1/24/25, 2/7/25, 2/8/25, 2/14/25, and 2/21/25. No new orders were	03/24/2025

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	depression. The resident's meal consumption records lacked documented values on the following dates and times: - 01/10/25 at dinner, - 01/11/25 at lunch, - 01/15/25 at dinner, - 01/17/25 at dinner, - 01/22/25 at lunch, - 01/24/25 at breakfast and dinner, - 02/07/25 at lunch, - 02/08/25 at lunch, - 02/14/25 at lunch, and - 02/21/25 at breakfast and lunch. 2. The clinical record for Resident 36 was reviewed on 02/24/25 at 12:53 P.M. A Significant Change MDS assessment, dated 12/24/24, indicated the resident was severely cognitively impaired. The resident's diagnoses included, but were not limited to, anemia, heart failure, hypertension, Non-Alzheimer's dementia, and depression. The resident had weight loss and was not on a prescribed weight loss regimen. The resident's meal consumption records lacked documented values on the following dates and times: - 01/10/25 at dinner, - 01/11/25 at lunch, - 01/15/25 at dinner, - 01/17/25 at dinner, - 01/22/25 at lunch, - 01/24/25 at breakfast and dinner, - 02/07/25 at lunch, - 02/08/25 at lunch, - 02/14/25 at lunch,		received. Resident #36's physician was contacted and notified of missed meal consumption 1/10/25, 1/11/25, 1/15/25, 1/17/25, 1/22/25, 1/24/25, 2/7/25, 2/8/25, 2/14/25, 2/21/25, and 2/23/25. No new orders were received **2)** **How other residents having the potential to be affected by t he** **same deficient practice will be identified and what corrective action(s) will be taken.** All residents receiving meals have the potential to be affected by the alleged deficient practice. A review was completed on all residents to ensure appropriate meal consumption documentation. The DNS/designee in-serviced nursing staff on the Delivery and Documentation of Meal Service and Between Meal Nourishment Policy. **3)** **What measures will be put into place or what systemic changes will be made to ensur e** **that the deficient practice does not recur?** The DNS/designee in-serviced facility nursing staff on meal documentation. The DNS/designee will review meal documentation compliance daily	

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	- 02/21/25 at breakfast and lunch, and - 02/23/25 at lunch. During an interview, on 02/26/25 at 10:32 A.M., Certified Nurse Aide (CNA) 4 indicated after each resident meal the staff were to document their meal consumption into the computer system. The current facility policy titled, "Delivery and Documentation of Meal Service and Between Meal Nourishment", was provided by the Director of Nursing (DON) on 02/26/25 at 1:37 P.M. The policy indicated, "...It is the policy of this facility that residents receive their meals and nourishments in a timely, courteous, and helpful manner as well as accurately document nutritional intake and food substitutes...Reviewing and documenting food and fluid intake following each meal..." 3.1-46(a)(1)		during the clinical meeting. **4)** **How the corrective action(s) will be monitored to ensure the** **deficient practice will not recur , i.e. what quality assurance program will be put into place?** To ensure compliance the DNS/designee will complete the Food and Fluid Documentation audit tool, weekly x 4 weeks, then monthly x 6 months, and quarterly thereafter. CQI committee will determine need for further review. The results of these audits will be reviewed by the CQI Committee, if threshold of 100% is not achieved an action plan will be completed. Deficiency in this practice will result in disciplinary action up to and including termination. 5) Completion Date: ___3/24/25____ ____	
F 0727 SS=E Bldg. 00	483.35(b)(1)-(3) RN 8 Hrs/7 days/Wk, Full Time DON Based on interview and record review, the facility failed to provide the required Registered Nurse (RN) on duty for eight consecutive hours a day for 2 of the 16 days reviewed. Findings include: The "as worked" nursing schedule from July to September 2024 indicated there had not been an RN on duty for eight consecutive hours on	F 0727	F727 **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** The facility has obtained RN coverage for 8 consecutive hours a day/ 7 days a week. **How will you identify other**	03/24/2025

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	Saturday, 09/28/24, and Sunday, 09/29/24. During an interview on 02/26/25 at 3:25 P.M., the Director of Nursing (DON) indicated the schedule usually had an RN on duty for 8 hours each day. She was unsure why those two days did not have coverage. During an interview on 02/26/25 at 3:29 P.M., the Administrator indicated the facility did not have a policy for RN coverage, they followed State and Federal regulations. The facility did not currently have any nursing waivers. 3.1-17(b)(3)		**residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All residents have the potential to be affected by the alleged deficient practice. The daily staffing is reviewed by the Executive Director and the DNS to ensure that RN coverage is in place. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** The daily staffing is reviewed by the Executive Director and the DNS to ensure that RN coverage is in place. If RN coverage is needed, the facility will utilize RN management and in house staffing agency for RNs. The Executive Director and DNS are continuing to recruit and hire RNs, full and part time. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e.; what quality assurance program will be put into place?** To ensure compliance the ED/DNS will review the staffing schedule showing RN coverage monthly for 6 months with the CQI Committee, after which the CQI team will re-evaluate the continued need for review. If RN coverage	

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			has not been achieved as required, an action plan will be developed, and review will continue until RN coverage has been achieved 7 days a week for 8 consecutive hours. Date of compliance: 3/24/25	
F 0756 SS=D Bldg. 00	483.45(c)(1)(2)(4)(5) Drug Regimen Review, Report Irregular, Act On Based on interview and record review, the facility failed to follow pharmacy recommendations for 1 of 6 residents reviewed for medication irregularities. (Resident 65) Findings include: The clinical record for Resident 65 was reviewed on 02/24/25 at 11:14 A.M. A Quarterly Minimum Data Set (MDS) assessment, dated 12/06/24, indicated the resident was moderately cognitively impaired. The resident's diagnoses included, but were not limited to, hypertension, diabetes, cirrhosis, malnutrition, and anemia. A Pharmacy Consultation Report, issued on 01/2/25, indicated the resident received iron replacement therapy with ferrous sulfate 325 milligrams (mg) given every other day. The recommendation was to optimize the iron therapy with Ferrex 150 mg to be given daily and discontinue the ferrous sulfate. The recommendation was signed by the pharmacist on 01/02/25. The physician responded on 02/07/25 and agreed with the recommendation. The February 2025, Electronic Medication Administration Record (EMAR) indicated the resident's ferrous sulfate had continued to be	F 0756	**F 756 Drug Regimen Review, Report Irregular** **1) What corrective action will be accomplished for those residents found to have been affected by the deficient practic e?** Resident #65 EMARs were reviewed on 2/26/25 at which time the physician was notified of orders 2/7/25 not being initiated per MD order. Resident #65's order was updated __3/3/25. Medications reconciled on 3/3/25. **2)** **How other residents having the potential to be affected by t he** **same deficient practice will be identified and what corrective action(s) will be taken.** All residents having pharmacy recommendations have the potential to be affected by the alleged deficient practice. A pharmacy recommendation audit was completed on 3/21/25 to ensure all orders were transcribed properly for the last 30	03/23/2025

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	given every other day and the EMAR lacked the physician's new order for Ferrex 150 mg every day. During an interview on 02/26/25 at 2:00 P.M., The IP Nurse indicated the signed recommendations were given to the nurse working on the resident's hall to transcribe the physician order. She wasn't sure why the medication changes weren't made for this resident. The current facility policy, titled "Medication Regimen Reviews and Pharmacy Recommendations", with a revised date of 10/2018, was provided by the Director of Nursing on 02/26/25 at 2:41 P.M. The policy indicated, "...Pharmacy recommendations should be reviewed with follow up by the physician within 30 days of the facility receiving...once reviewed by the physician the pharmacy recommendations will be filed in the resident's medical record..." 3.1-25(i)		days. The DNS/designee re-educated the facility nurses on the Medication Regimen Reviews and Pharmacy Recommendation Policy. **3)** **What measures will be put into place or what systemic changes will be made to ensur e** **that the deficient practice does not recur?** The DNS/designee in-serviced facility nurses on following physician orders r/t pharmacy recommendations. The DNS/designee will review all new orders daily during morning meeting to ensure accuracy per MD order. **4)** **How the corrective action(s) will be monitored to ensure the** **deficient practice will not recur , i.e. what quality assurance program will be put into place?** To ensure compliance the DNS/designee will complete the Pharmacy Services and Recommendation CQI audit tool, weekly x 4 weeks, then monthly x 6 months, and quarterly thereafter. CQI committee will determine need for further review. The results of these audits will be reviewed by the CQI Committee, if threshold of 100% is not achieved an action plan will be completed.	

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			Deficiency in this practice will result in disciplinary action up to and including termination. **5)** **Completion Date: 3/24/25**	
F 0759 SS=D Bldg. 00	483.45(f)(1) Free of Medication Error Rts 5 Prcnt or More Based on observation, interview, and record review, the facility failed to prevent medication errors for 1 of 4 residents reviewed for medication administration. (Resident 69) Findings include: During an observation of medication administration on 02/24/25 at 11:46 A.M., Licensed Practical Nurse (LPN) 2 indicated she needed to administer insulin to Resident 69. The LPN opened the top drawer of the medication cart, removed a vial of insulin, an alcohol swab, and a syringe. She wiped the top of the vial with the alcohol swab, inserted the needle and drew up 2 units into the syringe. The LPN placed the vial back into the drawer and locked it. She never turned on the computer to look at the resident's insulin order. At 11:48 A.M., the LPN went into the resident's room and was asked to not administer the medication and to verify the order. At 11:49 A.M., LPN 2 went back to the medication cart and turned on the computer to Resident 69's Electronic Medication Administration Record (EMAR). The LPN indicated the resident's blood sugar had been 207. She documented the blood sugar value into the insulin sliding scale order and determined the resident needed 6 units of insulin. The LPN indicated the resident's insulin sliding	F 0759	**F 759 Free of Medication Errors** **1)What corrective action will be accomplished for those residents found to have been affected by the deficient practic e?** Resident 69 is receiving insulin according to physician orders. DNS/Designee conducted medication pass skills validation with LPN 2. **2)** **How other residents having the potential to be affected by t he same deficient practice will be identified and what corrective action(s) will be taken.** All residents receiving insulin potential to be affected by this alleged deficient practice. An audit was completed on all sliding scale insulin orders to identify any other residents with medication errors. DNS/Designee conducted medication pass skills validation with all licensed staff. **3)** **What measures will be put**	03/24/2025

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	155377	A. BUILDING 00 B. WING	02/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SEYMOUR CROSSING	707 S JACKSON PARK DR SEYMOUR, IN 47274

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	scale order must have changed recently and proceeded to get new supplies to administer 6 units instead of 2 units. The nurse then went to the resident's room and administered 6 units to the resident. During an interview, on 02/26/25 at 11:36 A.M., LPN 3 indicated, when administering medications to residents, the nurse should follow the five rights of medication administration. The five rights were the right resident, right medication, right dose, right route, and right time. The clinical record for Resident 69 included a current, open-ended, physician's order, with a start date of 02/19/24, for the resident to be administered Aspart insulin per sliding scale. The sliding scale indicated the resident was to receive the following insulin per their blood sugar test results: - For a blood sugar result of 0 to 150, the resident was to have 0 units. - For a blood sugar result of 151 to 200, the resident was to have 3 units. - For a blood sugar result of 201 to 250, the resident was to have 6 units. - For a blood sugar result of 251 to 300, the resident was to have 9 units. - For a blood sugar result of 301 to 350, the resident was to have 12 units. - For a blood sugar result of 351 to 400, the resident was to have 15 units. - If the resident's blood sugar was greater than 400, the resident was to have 18 units, and the provider was to be notified. The current facility policy titled, "General Dose Preparation and Medication Administration", with a revision date of 11/15/24, was provided by the		**into place or what systemic changes will be made to ensur e that the deficient practice does not recur?** DNS/designee will conduct inservice with licensed nursing staff related to following physician orders for insulin administration. Daily EMAR audits will be completed by DNS/Designee to ensure insulin administration is being administered per physician orders. Residents receiving sliding scale insulin will have DNS/Designee observe insulin administration to ensure MD orders are followed. **4) How the corrective action(s) will be monitored to ensure the deficient practice will not recur , i.e. what quality assurance program will be put into place?** To ensure compliance the DNS/Designee will complete the Medication Error CQI audit tool, weekly x 4 weeks, then monthly x 6 months, and quarterly thereafter. CQI committee will determine need for further review. The results of these audits will be reviewed by the CQI Committee, if threshold of 100% is not achieved an action plan will be completed. Deficiency in this practice will result in disciplinary action up to and including termination.	

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	DON (Director of Nursing) on 02/26/25 at 1:37 P.M. The policy indicated, "...Only prepare medications for one resident at a time, using a 3-way-check (i.e., comparing the medication to the MAR and to the prescription label)...Verify each time a medication is administered that it is the correct medication, at the correct dose, at the correct route, at the correct rate, at the correct time, for the correct resident..." The current facility policy titled, "Medication Error", with a revision date of 11/2018, was provided by the DON on 02/26/25 at 1:37 P.M. The policy indicated, "...It is the policy of this provider to ensure residents residing in the facility are free of medication errors..." 3.1-48(c)(1)		**5)** **Completion Date: 3/24/25**	
F 0760 SS=D Bldg. 00	483.45(f)(2) Residents are Free of Significant Med Errors Based on interview and record review, the facility failed to prevent a significant medication error for 1 of 5 residents reviewed for unnecessary medications. (Resident 278) Findings include: During an interview on 02/25/25 at 10:34 A.M., Licensed Practical Nurse (LPN) 5 indicated residents' laboratory (labs) collections were sent out to a company in Indianapolis or Kentucky and not kept local. The company would come, obtain the labs, and take them with them. They came to the facility Monday through Friday. The nurse was able to look at the residents' clinical record for the lab results, fax the results to the Nurse Practitioner (NP), and put a copy in the NP's binder at the facility. For residents that needed a	F 0760	Past Noncompliance	03/24/2025

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	PT/INR (Prothrombin Time/International Normalized Ratio, a test to measure how quickly your blood clots), the NP would order the lab test. The results were called to the physician before the next dose of medication was administered because the facility needed to know if the medication dose needed to be changed. During an interview on 02/26/25 at 10:46 A.M., the NP indicated she required the facility to send the residents' PT/INR results to her office the same day the lab was obtained to be able to either keep the same dose or change the dose for that night. The clinical record for Resident 278 was reviewed on 02/25/25 at 9:23 A.M. An Admission MDS (Minimum Data Set) assessment, dated 02/13/24, indicated the resident was cognitively intact. The resident's diagnoses included, but were not limited to, hypertension, diabetes, anxiety, depression, and cerebrovascular accident. A physician's order, dated 02/14/25, indicated the staff were to obtain a PT/INR and it was to be sent to the local hospital for Coumadin therapy. A physician's order, dated 02/10/25 through 02/18/25, indicated the resident was to be administer Coumadin (Warfarin), 7.5 mg (milligrams), daily at 5:00 P.M. The February 2025 Electronic Medication Administration Record/Electronic Treatment Administration Record (EMAR/ETAR) indicated the residents PT/INR was obtained on 02/14/25. A Lab Report for a PT/INR indicated the lab was drawn on 02/14/25 at 10:05 A.M., and received in the lab on 02/15/25 at 12:04 A.M. The results, dated 02/15/25 at 8:59 A.M., indicated the PT/INR			

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	was high. The clinical record lacked any indication the physician was notified of the PT/INR results until 02/17/25. The February 2025 EMAR/ETAR indicated the resident had received the Coumadin medication of 7.5 mg, from 02/14/25 through 02/16/25. During an interview on 02/25/25 at 2:54 P.M., the Director of Nursing (DON) indicated the resident's PT/INR lab was completed on Friday, 02/14/25. The facility didn't receive the results until the following Monday, on 02/17/25. The staff should have called the NP on Friday, 02/14/25, before administering the Coumadin medication due to not having the PT/INR results. All of the staff had been educated on obtaining PT/INR results before administering the medication to see what the physician would like to do and to started monitoring residents that took Coumadin. The current facility policy titled, "Coumadin/Warfarin Monitoring Policy and Tracking Log", with a revised date of 11/2018, was provided by the DON on 02/25/25 at 3:36 P.M. The policy indicated, "...Residents who require Coumadin Therapy are receiving adequate monitoring...Prior to administering the Coumadin/Warfarin dose the licensed nurse should verify the most current PT/INR..." The deficient practice was corrected, on (02/17/25, prior to the start of the survey and was therefore Past Noncompliance. The facility reviewed all the residents' laboratory results for timeliness, educated staff, and implemented a process to monitor the residents' ordered laboratory test and laboratory results for physician notification.			

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	3.1-48(c)(2)			