STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165478	A. Building B. Wing	12/19/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arbor Court	701 East Mapleleaf Drive Mount Pleasant, IA 52641

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 0757 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42134 Based on clinical record review, physician interview, staff interview and hospital record review, the facility failed to respond to a warning for possible interaction between an antibiotic and anticoagulant medication and failed to intervene appropriately once new bruising was observed in multiple locations, which was an indicator of an adverse side effect of an anticoagulation medication for 1 of 2 (Resident #1) residents reviewed on anticoagulant therapy. The facility reported a census of 56 residents. This 2567 had been amended on February 3, 2023. Findings include: Resident #1's Admission Minimum Data Set (MDS) dated [DATE] documented an admitted [DATE]. The MDS documented a Brief Interview for Mental Status (BIMS) of 15, which indicated no cognitive impairment. The MDS documented the resident received an anticoagulation medication each of the last 7 days. Progress Note written on 11/30/22 at 2:56 PM documented a request sent out to the Primary Care Provider (PCP) for the next INR (lab test to measure anticoagulant) due date. Progress Note written on 11/30/22 at 6:41 PM documented the PCP ordered the INR to be drawn in 2 weeks, on December 14, 2022. Progress Note written on 12/5/22 at 6:30 PM documented the PCP was notified of the resident having an elevated temperature throughout the PM shift, nausea and dizziness. Progress Note generated by the Electronic Health Record (EHR) on 12/5/22 warned of a possible drug interaction between Jantoven (warfarin, Coumadin) 5 milligrams (mg) given daily for blood thinning and the antibiotic Keflex. The EHR identified the interaction as a moderate severity. The use of the medications together had the potential to increase the risk of bleeding complications. The Progress Notes lack notification to the PCP of the warning. The Progress Notes lack documentation of the PCPs decision and rationale for using the medications together despite the risk of interaction. Progress Note written on 12/11/22 at 8:11 PM documented turned resident to side, wound on sacrum draining large amount of (continued on next page)

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.

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

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F 0757 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	foul smelling red and black substance. Appears to be blood. Dressing changed, and resident repositioned. New bruising on the resident's left shin, left upper back, and on her ribs on the left side. The bruises were purple on color. The Advanced Registered Nurse Practioner (ARNP) was made aware of bruising and other assessment findings. The Progress Note documented her response as if giving blood thinners twice a day, decrease to once a day. It was noted the resident would be having an INR drawn in 3 days. The resident's Care Plan alerted staff the resident was on an anticoagulant and it required lab monitoring. The resident was identified as not needing terminal care. The Medication Administration Record (MAR) for Resident #1 included warfarin 5 milligrams (mg) daily. It was given daily from 12/1/22 thru 12/10/22. It was not given on 12/11/22 or 12/12/22. Review of the hospital records for Resident #1 (Clinical Report dated 12/12/22 under History of Present Illness) documented that her INR was therapeutic on 11/29/22 at 2.9 (normal for this resident's use of the medication is 2.0 to 3.0). Review of the hospital records, Clinical Report dated 12/12/22 documented that when the resident arrived in the emergency room her INR was greater than 17.3 (the lab analyzer could not actually determine a level as it did not read that high). The lab results document an INR of over 10 is considered critical for a resident on warfarin therapy. During an interview on 12/14/22 at 3:29 PM the Emergency Department (ED) physician stated when the resident was admitted to the ED on 12/12/22 she had bruising on her arms, legs and trunk. Her hemoglobin (hgb- protein that carries oxygen to the tissues and organs) was low. The physician reported that the resident was found to have a gastrointestinal bleed (GI Bleed) and had lost about 4 units of blood presumably through her stools. The hospital was setting up a unit of blood to give to the resident but she passed before it was ready. During an interview on 12/15/22 at 11:52 AM the PCP stated he was notified on 12/5/22 that the resident was not feeling well. She had an elevated temperature and nausea. He stated he ordered Keflex for the elevated temperature and because she had a pressure ulcer on her sacrum. Stated he was concerned she may be developing an infection in that and so the antibiotic was for skin bacteria. He stated he requested and received a status update on 12/7/22. He ordered some blood tests. The bloodwork came back with her hgb at 11.6, she was a little anemic. He stated he did not receive notification about the possible interaction between the warfarin and the Keflex. He stated she had previously used warfarin and Keflex together successfully many times. He stated if her intakes decreased that could cause her warfarin to be more potent but did not feel the Keflex was the cause. He stated he was not notified of the resident's decreased intakes and he was not notified prior to sending her to the ED on 12/12/22. (continued on next page)

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F 0757 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 12/15/22 at 10:28 AM Staff A stated if she had a question about a medication dosage or interaction there was a drug book available for reference. She was unable to locate the book. She entered the Director of Nursing's (DON) office to ask about the book. After a few minutes, the surveyor entered the DON's office to see if they had found the book. The DON was on her computer and stated she was looking for it. A minute later Staff A and the DON entered the medication room to look for the book. Staff A came out of the medication room and stated there was not a book in there. The Clinical Nurse Consultant entered the nurses station and stated the medication information was in the EHR. He was unable to locate it or show staff where to find it. The DON stated there is a single desktop computer at the nurses station that has full Internet access. She stated they could either use that or their personal cell phones to Google medications if they had a question about dosages or interactions. She stated they do not issue facility phones to use for references. An Immediate Jeopardy (IJ) was identified on 12/15/22 (with the start date being noted as 12/5/22), and the facility was notified of the IJ on 12/15/22. The IJ was removed on 12/15/22 when the facility developed and implemented the following corrective action plan: -Facility Nurses were educated by the DON/Admin on 12/15/22 policies PCU56-Medication Monitoring, PCU-58Medication Discrepancies and Adverse Medication Reactions -Facility Nursing staff were educated on policy NursA.9 Notification of Change in Resident Condition by DON/Admin. -Staff educated on 12/15/22 on monitoring PCC for alerts for potential drug/drug interactions by DON -Staff educated on the importance of monitoring bruising on residents with Anticoagulant therapy on 12/15/22 for Dr. Notification by DON -Facility did a 100% audit on all residents on Coumadin to ensure appropriate routine lab in place for PT/INR. Don completed this audit The scope and severity level of the IJ deficiency was lowered from a J to an G at the time of the survey after the facility completed the above removal plan.