DELAWARE HEALTH AND SOCIAL SERVICES
Division of Health Care Quality
Office of Long-Term Care Residents Protection

DHSS - DHCQ
263 Chapman Road, Ste 200, Cambridge Bldg.
Newark, Delaware 19702
(302) 421-7400

STATE SURVEY REPORT

NAME OF FACILITY: WillowBrooke Court at Cokesbury Viillage **DATE SURVEY COMPLETED:** October 3, 2023

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	An unannounced Annual, Complaint and Emergency Preparedness Survey was conducted at this facility from September 28, 2023 through October 3, 2023. The deficiencies contained in this report are based on interviews, review of residents' clinical records and review of other facility documentation as indicated. The facility census on the first day was 32. The sample totaled seven residents. Abbreviations/definitions used in this report are as follows: CNA - Certified Nurse's Aide; DAL - Director of Assisted Living; DON - Director of Nursing; ED - Executive Director; LPN - Licensed Practical Nurse; NHA - Nursing Home Administrator; NP - Nurse Practitioner; RN - Registered Nurse; House stock - common medications available for patient usage prior to delivery of that specific patient's medications from the pharmacy; Omnicell - an automated, computerized machine that stores and manages medications including narcotics in a healthcare setting.		11/30/23
3201 **3201.1.0** **3201.1.2**	**Regulations for Skilled and Intermediate Care Facilities** **Scope** **Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for**	3201.6.8.1.14 a.) No resident was directly affected. We are unable to retrospectively correct this action. Event was reported when DON became aware that it was a reportable event on 8/22/22. DON or designee will be responsible for ensuring compliance going forward. RCA revealed that there was a knowledge deficit of the DON regarding reporting requirements and reporting timeframes. b.) A retrospective audit of Incident Reports of the past 60 days will be conducted by the DON or designee to validate that all required reportable incidents have been reported to DHCQ in the appropriate time frame.	

Provider's Signature Kleenex NHA Title NHA Date Revised 1-2-24

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	Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference. **This requirement is not met as evidenced by:** Cross refer to the CMS 2567-L survey completed on 10/3/23: F635, F758, F812, F842. **Services To Residents** **Medications** **The administrator or designee shall notify the Office of Controlled Substances in the Division of Professional Regulation and the Division of Long Term Care Residents Protection of any unexplained loss of controlled substances, syringes, needles, or prescription pads within 8 hours of discovery of such loss or theft.** **This requirement was not met as evidenced by:** Based on record review and interview, it was determined that the facility failed to report the missing narcotics (noted as missing on 8/10/22) to the State Division of Health Care Quality (DHCQ) within the	c.) There was a knowledge deficit of the DON regarding reporting time requirements. DON, ADON, and DAL will be educated by the NHA on reportable Incidents and timelines for reporting to DHCQ. The DON has also attended the DE State DON training in June of 2023. d.) Audits of incident reports will be conducted by NHA or designee 5 days per week x 1 week to validate that reportable events are being reported timely, until 100% threshold of compliance is met. Then audits will be conducted 3x per week x 1 week until 100% compliance is reached. Then audits will be conducted 1x per week until 100% compliance is reached. Then audits will be conducted monthly x1 month until 100% compliance is reached. When audit cycles have been completed and there is 100% compliance, the QAPI committee will review and make recommendations on continued plan of action or discontinuation of auditing.	

Provider's Signature [signature] Title NHA Date 1-2-24

NAME OF FACILITY: WillowBrooke Court at Cokesbury Viillage **DATE SURVEY COMPLETED:** October 3, 2023

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	required eight-hour timeframe. Findings include: Review of the facility records revealed: 8/8/22 - The facility's pharmacy hand delivered four lorazepam (Class IV controlled substance antianxiety medication) tablets that were requested by the facility. The four lorazepam tablets should have been loaded by the nurse, who signed for the delivery, in the house stock (common medications stored and available for patient administration that can be used for patient care prior to delivery of that specific patient's medications from the pharmacy) of the Omnicell (an automated, computerized machine that stores and manages medications including controlled substances in a healthcare setting). 8/10/22 - Pharmacy notified E2 (DON) that the lorazepam tablets had not yet been loaded into the Omnicell floor stock. Pharmacy requested the medications be located and loaded into the Omnicell floor stock. 8/22/22 11:10 AM - E2 (DON) reported the four missing lorazepam tablets to DHCQ twelve days after the facility was notified from the pharmacy that the medication was missing. 9/2/23 1:34 PM – During an interview, E2 (DON) confirmed the finding. The facility failed to notify DHCQ of the missing narcotics within the required timeframe.		

Provider's Signature [signature] Title DNHA Date 1-2-24

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SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
16 Del. C. Chapter 11 Subchapter VII §1161	10/3/23 2:44 PM - Finding was reviewed during the Exit Conference with E1 (NHA), E2 (DON), E3 (ADON), E4 (ED) and E5 (DAL). **Health and Safety Regulatory Provisions Concerning Public Health** **Long-Term Care Facilities and Services** **Minimum Staffing Levels for Residential Health Facilities** **(f) "Nursing supervisor" shall mean an advanced practice nurse or registered nurse who is assigned to supervise and evaluate nursing services direct caregivers no less than 25 percent of the nursing supervisor's time per shift.... There shall be a nursing supervisor on duty and on-site at all times.** **This requirement was not met as evidenced by:** Based on interview and review of facility records, the facility failed to ensure a Registered Nurse (RN) Supervisor was on duty and on-site in the Healthcare Center (HC) at all times. Findings included: Review of the facility records revealed: 4/21/23 – The facility's Staff Posting revealed one RN was scheduled from 3:00 PM to 7:00 PM, one Licensed Practical Nurse (LPN) was scheduled from 7:00 PM to 11:00 PM and one LPN was scheduled from 3:00 PM to 11:00 PM. Review of the	Chapter 11, Sub Chapter VII, 1161 a.) No residents were directly affected. We are unable to retrospectively correct this action. DON or designee will be responsible for ensuring compliance going forward. RCA revealed that there was a knowledge deficit of the DON and former NHA regarding stationed location assignment of the RN on duty. b.) Retrospective audit of daily schedules will be completed for	11/30/23

Provider's Signature [signature] Title NHA Date 1-2-24

NAME OF FACILITY: WillowBrooke Court at Cokesbury Viillage **DATE SURVEY COMPLETED:** October 3, 2023

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	facility's timecards confirmed the staffing in HC. 10/3/23 at 12:30 PM – During a phone interview, E9 (LPN) confirmed that E11 (RN) was called to HC from the Assisted Living area in the building to pronounce R7, who had expired. 10/3/23 at 1:00 PM – During a phone interview, E11 (RN) confirmed that she received a call from E9 (LPN) working in HC while she was working in Assisted Living. E11 (RN) stated that she told E9 (LPN) that she was on a phone call with the hospital at that time regarding a resident in Assisted Living and would come to HC after the phone call. The facility failed to ensure an RN Supervisor was on duty and on-site at all times in HC. 10/3/23 at 2:44 PM - Finding was reviewed during the Exit Conference with E1 (NHA), E2 (DON), E3 (ADON), E4 (ED) and E5 (DAL).	the previous 30 days (9/2/22-10/2/23) to ensure that this was an isolated occurrence. Any incident of non-compliance will be brought to the QAPI committee for a further action plan. c.) There was a knowledge deficit of the DON and previous NHA regarding the need to the RN to be physically stationed on the skilled unit, and not on another unit. Nursing Leadership Staff (DON, ADON, DAL, RNAC) will be educated by the NHA on Eagle's Law requirements of having the RN Supervisor physically stationed on the Willow Brook Court skilled unit at all times. The DON also attended the DE State DON training in June of 2023. DON or Designee will review daily schedules at the beginning of each week to validate that there is a	

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		RN supervisor stationed and assigned to the skilled area. d.) NHA or designee will audit daily schedules to validate that the RN supervisor is scheduled 24 hours daily on the skilled unit, 5 days per week x 1 week until 100% compliance is met, then 2x per week x 1 week until 100% compliance is met, then monthly x 1month. When audit cycle is completed and 100% compliance is reached, the QAPI committee will review and make recommendations on continued plan of action or discontinuation of auditing.	

Provider's Signature _____ Title NHA Date 1-2-24

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	085017	A. BUILDING _____ B. WING _____	C 10/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOWBROOKE COURT AT COKESBURY VILLAGE	726 LOVEVILLE ROAD HOCKESSIN, DE 19707

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted at this facility beginning September 28, 2023 through October 3, 2023 by the State of Delaware Division of Health Care Quality, Office of Long Term Care Residents Protection in accordance with 42 CFR 483.73. Facility census on the first day was 3. For the Emergency Preparedness survey, all contracts, operation plans, contact information, and annual emergency drills were up to date. No deficiencies were identified.	E 000		
F 000	INITIAL COMMENTS An unannounced Annual, Complaint and Emergency Preparedness Survey was conducted at this facility from September 28, 2023 through October 3, 2023. The deficiencies contained in this report are based on observations, interviews, review of residents' clinical records and review of other facility documentation as indicated. The facility census on the first day was three residents. The sample totaled three residents. Abbreviations/definitions used in this report are as follows: CNA- Certified Nurse's Aide; DAL- Director of Assisted Living; DON- Director of Nursing; ED- Executive Director; LPN- Licensed Practical Nurse; NHA- Nursing Home Administrator; NP- Nurse Practitioner; RN- Registered Nurse;	F 000		

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

Electronically Signed | 10/23/2023

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 000	Continued From page 1 anticoagulation- a process of preventing the clotting of blood; atrial fibrillation- an irregular heart rhythm that increases risk for blood clots; dialysis- the process of purifying the blood int he absence of normal kidney function; EMR- electronic medical record; hemodialysis- a medical procedure that utilizes a machine to filter wastes and water from human blood in the absence of normal kidney function; physiologic- a vital process or function of a living organism.	F 000		
F 635 SS=D	Admission Physician Orders for Immediate Care CFR(s): 483.20(a) §483.20(a) Admission orders At the time each resident is admitted, the facility must have physician orders for the resident's immediate care. This REQUIREMENT is not met as evidenced by: Based on record review, observation, and interviews, it was determined that for one (R4) out of one resident reviewed for dialysis, the facility failed to ensure that R4's admission physician's orders dated 8/8/23 included hemodialysis treatments for Tuesday, Thursday and Saturday. Findings include: 8/8/23 - R4 was admitted to the facility with diagnoses including but limited to: atrial fibrillation (irregular heart rhythm that increases risk for blood clots) and chronic kidney disease (stage 5) with R4 being dependent on renal dialysis. 8/9/23 - R4 was care planned for hemodialysis with interventions including; "encourage me to go to my scheduled dialysis appointments" and	F 635	1) Order was obtained for dialysis for R4 by ADON on 10/3/23. 2) Review of current residents was conducted by DON. No other residents are receiving dialysis. 3) Licensed nurses will be educated by the Staff Development Coordinator of need for dialysis orders when a resident begins dialysis, or is admitted on dialysis services. 4) A root cause analysis determined that there was a knowledge deficit of the nurse writing the admission orders. New admission records will be audited by the DON or designee 1x weekly for presence of dialysis services and accompanying order if services are required, until 100%	11/30/23

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F 635	Continued From page 2 "monitor for dressing site on my right chest wall. Dressing is changed at dialysis." 9/28/23 11:15 AM - This surveyor observed R4's bed was empty and was unable to find R4. During an interview, E6 (LPN) stated that R4 was at his hemodialysis appointment and usually arrives back at the facility around 4:30 PM. 9/29/23 9:14 AM - During an interview, R4 confirmed that he leaves the facility to go to an off-site hemodialysis unit every Tuesday, Thursday and Saturday. R4 stated that his wife drives him to the dialysis center and that his chair time is 11 AM. 10/2/23 1:25 PM - During an interview, E2 (DON) confirmed that there was not an order for hemodialysis treatments on Tuesday, Thursday and Saturday on R4's EMR. 10/3/23 2:44 PM - Findings were reviewed during the Exit conference with E1 (NHA), E2, E3 (ADON), E4 (ED) and E5 (DAL).	F 635	compliance is achieved. Then 1x every other week until 100% compliance is achieved. Then once monthly until 100% compliance is achieved. Once 100% compliance is achieved monthly, request to discontinue audits will be submitted to the QAPI committee by DON.	
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic	F 758		11/30/23

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F 758	Continued From page 3 Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that for one (R307) out of three (3)	F 758	a. R307 now has a diagnosis of depression. The depression diagnosis has	

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F 758	Continued From page 4 residents sampled for the use of Unnecessary Medications, the facility failed to ensure that R307 received adequate monitoring for the use of a psychoactive medication. Findings include: 9/23/23 - R307 was admitted to the facility with diagnoses including but not limited to atrial fibrillation (irregular heart rhythm that increases risk for blood clots), vascular dementia without behavioral, psychotic or mood disturbance, and walking difficulty. 9/24/23 - E7 (NP) ordered Trazadone 150 mg (antidepressant) and melatonin 3 mg (sleep aid) daily at bedtime for the diagnosis of insomnia. 9/24/23 - R307's care plan documented, "I use the psychotropic medication Trazadone (antidepressant) related to my insomnia." The goals included but not limited to, " ...remain free of psychotropic drug related complications, including movement disorder, discomfort, low blood pressure..." The interventions included administer the psychotropic medications as ordered and monitor for side effects and effectiveness every shift. Review of the record lacked evidence of monitoring sleep for insomnia that required the use of medication. Additionally the facility failed to have evidence that the potential side effects of the Trazadone were being monitored. 10/3/23 2:44 PM - Findings were reviewed during the Exit Conference with E1 (NHA), E2 (DON), E3 (ADON), E4 (ED) and E5 (DAL).	F 758	been linked to the Trazadone. Diagnosis obtained by ADON from NP on 10/3/23. b. Care plan has been updated to reflect usage of Trazadone for depression diagnosis. c. Monitoring now in place for potential side effects of Trazadone. d. Insomnia sleep monitoring has been initiated for this resident. 2. a. All current WBC resident records will be audited for use of an antidepressant with an assigned diagnosis of insomnia. If this is found, NP will be requested to evaluate for depression and assign a depression diagnosis if indicated. If depression is not found, the antidepressant will be discontinued by NP and an appropriate drug for insomnia will be ordered. b. All current residents on antidepressants will be audited for routine monitoring for potential side effects. If routine monitoring is not in place, it will be initiated. c. All current residents with the diagnosis of insomnia will be audited to verify that monitoring of insomnia is in place. If insomnia monitoring is not in place, it will be initiated. 3. a. Licensed Nurses and NP will be educated on inability to use Trazadone for the diagnosis of insomnia and that it is to be used only with a diagnosis of depression. b. Licensed nurses will be educated on implementation of routine monitoring for side effects when an antidepressant is	

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F 758	Continued From page 5	F 758	ordered. c. Licensed Nurses will be educated to implement sleep monitoring in the presence of an insomnia diagnosis. d. Education will be completed by the staff development coordinator. 4. a. A root cause analysis revealed that there was a knowledge deficit of the nurse writing the order and a knowledge deficit of the NP for indicated use of Trazadone. Active resident records with new orders will be audited by the DON or designee for antidepressant use with a depression diagnosis along with implementation routine monitoring for side effects. Audit daily x 1 week until 100% compliant. Then audit 3x per week x 2 weeks until 100% compliant. Then audit 1x per week x 2 weeks until 100% compliant. Then audit monthly x 1 month until 100% compliant. Once 100% compliance is achieved monthly, a request to discontinue audits will be submitted to the QAPI committee. b. Active resident records with new diagnosis of insomnia will be audited by DON or designee for implementation of routine sleep monitoring. Audit daily x 1 week until 100% compliant. Then audit 3x per week x 2 weeks until 100% compliant. Then audit 1x per week x 2 weeks until 100% compliant. Then audit monthly x 1 month until 100% compliant. Once 100% compliance is achieved monthly, a request to discontinue audits will be submitted to the QAPI committee by DON.	
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary	F 812		11/30/23

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F 812	Continued From page 6 CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined that the facility failed to ensure that food was stored and prepared in a sanitary manner. Findings include: The initial kitchen tour on 9/28/23 from 9:00 AM - 9:45 AM revealed that two moldy boxes of strawberries were found in the walk-in refrigerator. 10/3/23 2:44 PM - Findings were reviewed during the Exit Conference with E1 (NHA), E2 (DON), E3 (ADON), E4 (ED) and E5 (DAL).	F 812	1. The moldy strawberries were not served to the residents and were immediately discarded. No residents were affected. 2. All strawberries in the refrigerators were inspected, no other moldy ones identified. 3. Receiver of produce will inspect produce as it is delivered for any spoiled product in the delivery. This will occur with each delivery and documented in a log. Sous chefs will monitor walk in refrigeration units daily for any spoiled products and documented in a log. 4. Chef will audit receiver log and Sous chef log daily for completion x1 week until	

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F 812	Continued From page 7	F 812	100% compliant. Then decrease to 3 x weekly for 1 week until 100% compliant. Then decrease to 1x weekly for one week until 100% compliant. Then 1x monthly for 1 month until 100% compliant. Once 100% compliance is achieved monthly, a request to discontinue audits will be submitted to the QAPI committee.	
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law;	F 842		11/30/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085017	A. BUILDING _____ B. WING _____	C 10/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOWBROOKE COURT AT COKESBURY VILLAGE	726 LOVEVILLE ROAD HOCKESSIN, DE 19707

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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 842	Continued From page 8 (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was	F 842	1. R4□s record was updated to include	

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F 842	Continued From page 9 determined that for one (R4) out of three residents reviewed for Unnecessary Medications, the facility failed to ensure that R4's medical record met with accepted professional standards and practices with regards to the anticoagulation order. Findings include: 8/8/23 - R4 was admitted to the facility with diagnoses including but limited to: atrial fibrillation (irregular heart rhythm that increases the risk for blood clots) and chronic kidney disease (stage 5) with R4 being dependent on renal dialysis. 8/8/23 - R4's electronic medical record (EMR) documented a verbal order from E7 (Nurse Practitioner) for "Eliquis oral tablet 5 mg (milligrams) (Apixiban)- give one tablet by mouth two times a day for anticoagulation (the process of preventing the clotting of blood)". Anticoagulation is not a medical diagnosis; it is a physiologic state. The medical diagnosis, which required that R4 be in a state of anticoagulation, was R4's diagnosis of atrial fibrillation. Therefore, atrial fibrillation should have been the medical diagnosis for the use of the drug, Eliquis. 10/2/23 1:25 PM - During an interview, E2 (DON) confirmed that the documented medical reason for the Eliquis order stated "anticoagulation". E2 also confirmed that "anticoagulation" was not a medical diagnosis. 10/3/23 2:44 PM - Findings were reviewed during the Exit conference with E1 (NHA), E2, E3 (ADON), E4 (ED) and E5 (DAL).	F 842	the medical diagnosis of a-fib for the medication Eliquis by ADON on 10/3/23. 2. All records of current residents receiving anticoagulants will be audited by DON or designee for appropriate diagnosis with the anticoagulant ordered. If there is not an appropriate diagnosis listed, NP will be asked to review the resident record and assign the appropriate diagnosis. If there is not an appropriate diagnosis, NP will be requested to evaluate resident for the need of anticoagulant therapy. 3. Licensed Nurses and NP will be educated by the staff development coordinator on need for listing the appropriate diagnosis with an ordered anticoagulant. 4. A root cause analysis determined that there was a knowledge deficit of the nurse writing the order. Active resident records with new order for an anticoagulant will be audited by DON or designee for appropriate diagnosis. Audit daily x 1 week until 100% compliant. Then audit 3x per week x 2 weeks until 100% compliant. Then audit 1x per week x 2 weeks until 100% compliant. Then audit monthly x 1 month until 100% compliant. Once 100% compliance is achieved monthly, a request to discontinue audits will be submitted to the QAPI committee by DON.	