Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL303531842M
Compliance #: HL303533510C

Date Concluded: March 28, 2023

Name, Address, and County of Licensee Investigated:
The Encore at Hugo
5607 North 150th Street
Hugo MN, 55038
Chisago County

Facility Type: Assisted Living Facility with Dementia Care (ALFDC)

Evaluator's Name: Kris Detsch, RN
Special Investigator

Finding: Not Substantiated

Nature of Investigation:
The Minnesota Department of Health investigated an allegation of maltreatment, in accordance with the Minnesota Reporting of Maltreatment of Vulnerable Adults Act, Minn. Stat. 626.557, and to evaluate compliance with applicable licensing standards for the provider type.

Initial Investigation Allegation(s):
The alleged perpetrator (AP) neglected a resident when they failed transcribe a medication order correctly and the resident received increased dosages of blood thinning medication. As a result, the resident's blood became too thin causing him to be at risk for bleeding.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. The facility investigated the medication error and identified an error in the medication transcription process. The facility implemented changes to prevent future occurrences. Although the medication error occurred, the resident was and treated in a timely manner. The resident returned to his baseline international normalized ratio (INR) status. The medication error was an isolated incident.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted family members. The

investigation included review of resident records, employee files, internal investigations, incident reports, and facility policies. The investigator observed medication administration. Also, the investigator toured the facility and observed interactions between staff and residents.

The resident resided in an assisted living memory care unit. The resident's diagnoses included heart disease, emphysema, and dementia. The resident's service plan included assistance with medication administration, mobility, showering, and a daily wellness check. The resident's nursing assessment indicated he was independent with dressing and grooming. The resident walked independently but required a walker. The resident was dependent upon oxygen. The resident was confused and at risk for falling.

The resident's medical record indicated he required INR blood testing because he received blood thinning medication. The physician ordered the resident to receive weekly INR testing because the resident's INR results were not in a therapeutic range. The physician adjusted the resident's blood thinning medication accordingly and increased the dosage of the resident's blood thinning medications twice over a two-month period. Seven days after the physician increased the dosage of the resident's blood thinning medication, the resident had another INR blood draw, and the results were critically high. The resident went to the hospital for treatment. While at the hospital, the resident received vitamin K to help reverse the effects of the blood thinning medication. The resident stayed overnight at the hospital for observation and returned to the facility the following day.

During an interview, a manager said she started an investigation to determine what would cause the resident to have a critically high INR result. The manager said she looked at the electronic medication record (eMAR) and found a discrepancy in the blood thinning medication order. The manager said the physician ordered two different dosages of blood thinning medication which staff were to rotate on specific days. The manager said the eMAR did not reflect the rotation of the medication dosages, and staff administered both of the dosages daily. The manager said adding new medications from the eMAR system was a two-way process. First, the pharmacy entered the medication into the facility's eMAR system, secondly, the nurse reviewed and approved the order. The manager said the nurse had to approve the order before it showed up in the eMAR system for other staff to administer the medication to the resident. The manager said she was unable to tell who entered the order incorrectly, but the nurse should have verified the accuracy of the order before approving it. The manager said she contacted the pharmacy and together they changed the process for staff administration of blood thinning medication. The manager said the pharmacy changed the packaging of the medications and placed "stop" dates for those medications. The manager said she educated staff on the new process.

During an interview, the AP said she was not aware a transcription error occurred. The AP said the facility did not contact her to inform her they thought she made a transcription error. The AP said she was no longer working at the facility during the time the resident received incorrect

medication dosages. The AP said she did “cross check” orders after the pharmacy entered them into the eMAR system.

The resident’s eMAR record indicated the pharmacy entered the orders correctly into the system with clearly written instructions for the medication rotation. The eMAR system failed to have the rotation days “blocked out”, however the eMAR system clearly indicated which medication dosage staff should administer each day. The eMAR indicated the AP had not administered blood thinning medication to the resident.

During an interview, a family member said the resident was in isolation for fourteen days after he returned to the facility because he tested positive for COVID. The family member said she saw the resident when he was out of isolation, and he appeared to be better than his baseline health status.

In conclusion, the Minnesota Department of Health determined neglect was not substantiated.

“Not Substantiated” means:
An investigatory conclusion indicating the preponderance of evidence shows that an act meeting the definition of maltreatment did not occur.

Neglect: Minnesota Statutes, section 626.5572, subdivision 17
"Neglect" means:
(a) The failure or omission by a caregiver to supply a vulnerable adult with care or services, including but not limited to, food, clothing, shelter, health care, or supervision which is:
(1) reasonable and necessary to obtain or maintain the vulnerable adult's physical or mental health or safety, considering the physical and mental capacity or dysfunction of the vulnerable adult; and
(2) which is not the result of an accident or therapeutic conduct.

Vulnerable Adult interviewed: Yes.
Family/Responsible Party interviewed: Yes.
Alleged Perpetrator interviewed: Yes.

Action taken by facility:
The facility worked with the pharmacy to put a system in place to reduce the risk of medication errors and provided education to staff.

Action taken by the Minnesota Department of Health:
The facility was issued a correction order regarding the vulnerable adult’s right to be free from maltreatment. To view a copy of the Statement of Deficiencies and/or correction orders, please visit: https://www.health.state.mn.us/facilities/regulation/directory/provcompselect.html
Or call 651-201-4890 to be provided a copy via mail or email. If you are viewing this report on the MDH website, please see the attached Statement of Deficiencies.

The responsible party will be notified of their right to appeal the maltreatment finding. If the maltreatment is substantiated against an identified employee, this report will be submitted to the nurse aide registry for possible inclusion of the finding on the abuse registry and/or to the Minnesota Department of Human Services for possible disqualification in accordance with the provisions of the background study requirements under Minnesota 245C.

cc:
The Office of Ombudsman for Long Term Care
The Office of Ombudsman for Mental Health and Developmental Disabilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30353	A. BUILDING: _____ B. WING _____	C 03/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ENCORE AT HUGO	5607 150TH STREET NORTH HUGO, MN 55038

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0 000	Initial Comments ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a complaint investigation. Determination of whether a violation is corrected requires compliance with all requirements provided at the statute number indicated below. When a Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: ***Revised*** #HL303533510C/#HL303531842M On March 14-16, 2023, the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction orders are issued. At the time of the complaint investigation, there were 16 residents receiving services under the provider's Assisted Living with Dementia Care license. The following immediate correction order is issued for #HL303533510C/#HL303531842M tag identification 330. On March 16, 2023, at 4:25 p.m., the immediacy of correction order 330 was removed, however noncompliance remained at a scope and level of F. The following correction orders are issued for	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	

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0 000	Continued From page 1 #HL303533510C/#HL303531842M, tag identification 650, 0750, 1760, and 2310.	0 000		
0 330 SS=F	144G.30 Subd. 4 Information provided by facility (a) The assisted living facility shall provide accurate and truthful information to the department during a survey, investigation, or other licensing activities. (b) Upon request of a surveyor, assisted living facilities shall within a reasonable period of time provide a list of current and past residents and their legal representatives and designated representatives that includes addresses and telephone numbers and any other information requested about the services to residents. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide the surveyor access to all requested records and information necessary for the investigation. This had the potential to affect all residents. This resulted in an immediate correction order. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). Findings Include: On March 14, 2023, at 9:02 a.m., surveyor entered facility and requested assistant	0 330		

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0 330	Continued From page 2 administrator (AD)-A to provide resident roster, staff roster, and daily schedule. In addition, surveyor requested accident, incident, grievance, and vulnerable adult reports for the last there months. Surveyor provided AD-A a list of requested information. AD-A said she would call the administrator because she was new in her position. On March 14, 2023, at 9:52 a.m., surveyor asked AD-A for requested information and received a copy of the daily schedule, but no other information. AD-A said the administrator was on her way into the facility and would provide information. On March 14, 2023, at 10:20 a.m., AD-B arrived, and surveyor requested resident roster, staff roster, in addition, surveyor requested accident, incident, grievance, and vulnerable adult reports for the last there months. On March 14, 2023, at 10:55 a.m., surveyor asked AD-B to provide requested information. AD-B provided staff roster. Surveyor made another request for the resident roster. AD-B provided resident roster. On March 14, 2023, at 11:25 a.m., surveyor request AD-B to provide requested accident, incident, grievance, and vulnerable adult reports for the last there months. Surveyor received a one-page copy of falls incident reports from December 15, 2022, through January 6, 2022. AD-B said there was difficulty printing information from their Yardi (electronic medical record) computer system. No other information provided. On March 14, 2023, at 1:00 p.m., surveyor met with AD-B and gave AD-B a list of R1's records	0 330		

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0 330	Continued From page 3 surveyor required. AD-B acknowledged understanding of the documentation surveyor was requesting. The documentation included: R1's face sheet, service plan, prescriber orders (May 2022 to July 2022), medication administration record, treatment record, progress notes, prescriber progress notes, RN assessments, abuse prevention plan, documentation of services, medication management assessment, medication management plan, treatment plan, and discharge assessment. In addition, surveyor requested employee files for two unlicensed personnel (ULP-1 and ULP-2). On March 14, 2023, at 2:00 p.m., AD-B provided no documentation. During an interview on March 14, 2023, at 2:10 p.m., AD-B said she sent surveyor an email with requested employee records. Surveyor showed AD-B there was no email received from AD-B. AD-B said they have been having Internet problems. AD-B gave surveyor ULP-1's nursing assistant registry verification, and facility disciplinary action. AD-B failed to provide further employee records. During an interview on March 14, 2023, at 2:19 p.m., AD-B acknowledged lack of staff's inability to print records from the Yardi system. AD-B acknowledged the lack of records provided to surveyor. AD-B acknowledged records should be provided in a timely manner. On March 14, 2023, at 2:50 p.m. the surveyor exited the building and received no further records. TIME PERIOD TO CORRECT: Immediate	0 330		

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0 330	Continued From page 4 On March 15, 2023, as of 11:26 a.m., surveyor has not received any requested information. On March 16, 2023, at 4:25 p.m., AD-C provided R1's medical record. AD-C said further requested documentation would be provided. On March 16, 2023, at 4:25 p.m., immediacy was removed and scope and severity level remained at a level F. On March 21, 2023, at 1:11 p.m., surveyor sent an email to AD-B and requested any medicaion error incident reports that occurred in May 2022 through August 2022. Also, surveyor requested a copy of the narcotic ledger from May 2022 through August 2022. Licensee failed to provide requested documentation to surveyor. TIME PERIOD FOR CORRECTION: Seven (7) days	0 330		
0 650 SS=F	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of	0 650		

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0 650	Continued From page 5 staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure employee records included required content for two of two employees (RN-D, and ULP- G) with records reviewed. ULP-G's employee record lacked documentation including medication errors, re-education, and lack of staff competency evaluations. RN-D's employee record could not be produced. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On March 14, 2023, at 9:20 a.m., the surveyor observed unlicensed personnel (ULP-G) administer medications for a resident (R2). The surveyor observed ULP-G set up R2's medications, administer them, and document the	0 650		

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0 650	Continued From page 6 medication administration. R2's medical record was reviewed. R2 admitted to the licensee on October 18, 2022, and received medication administration services. R2's diagnoses included diabetes, dementia, hypertension, and aortic valve disorder. On March 14, 2023, at 1:00 p.m., surveyor asked administrator (AD)-B for ULP-G and registered nurse (RN)-D employee files. On March 14, 2023, at 2:10 p.m., AD-B provided surveyor ULP-G's nursing assistant registry verification and disciplinary action forms. AD-B provided no further information. ULP-G was hired by the licensee at an unknown date. ULP-G's employee record included the following disciplinary action forms: - Discipline Action form dated December 8, 2021, indicated a supervisor provided re-education to ULP-G for, "Improper documentation and follow-up regarding the bandage on the resident's arm." -Verbal Coaching form dated December 20, 2021, indicated RN-E provided re-education to ULP-G for, "ULP-G documented multiple medications not given, not available, some medications were available in med cart and missed". -A handwritten note dated May 26, 2022, RN-D indicated she investigated a medication error. The written note indicated ULP-G had a history of a drug problem and had started using drugs	0 650		

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0 650	Continued From page 7 again, but not at licensee building. RN-D removed ULP-G from medication administration. -Discipline Action form dated June 17, 2022, no signature, indicated, "In an audit, and pointed out by another med aide, that the time and date are not added to her record of giving the controlled substance. There is crossing out of meds instead of one singe line though the error and sign and initial the error and reported to the DOW. Errors found are attached here to the narcotic logs". The Discipline Action form indicated ULP-G would be reomved from passing medications and would be re-evaluated in 30 days. During an interview on March 21, 2023, at 12:43 p.m., RN-D said she removed ULP-G from medication administration because she noticed the narcotic ledger had several lines scribbled out and not legible for several residents. RN-D said she did an investigation and did not find narcotic diversion, rather ULP-G was trying to cover up an error. RN-D said ULP-G gave a hospice resident a double dose of morphine. RN-D said ULP-G did not administer medications again while RN-D remained employed for licensee. RN-D said all information regarding the incident should be in ULP-G's employee file. On March 20, 2022, at 11:44 a.m., AD-B said she was unable to locate RN-D's employee file. The licensee failed to produce employee file for RN-D. On March 20, 2022, at 11:44 a.m., AD-B said she found no further information regarding ULP-G's employee file. AD-B acknowledged the lack of required employee file content in addition to documented competency for medication administration. The licensee failed to produce ULP-G's required record content including	0 650		

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0 650	Continued From page 8 orientation, required annual training, infection control training, competency evaluation, job description, annual performance reviews, and documentation of background study. Also, the licensee failed to produce evidence ULP-G demonstrated medication administration competency after licensee took disciplinary action and removed ULP-G from administering medication. Licensee's policy titled Organization of Personal Records dated September 2021, indicated a complete personnel record would be kept by licensee in a secure area and maintained for ten years following separation of employment. TIME PERIOD FOR CORRECTION: SEVEN (7) DAYS	0 650		
0 750 SS=D	144G.43 Subd. 5 Record retention Following the resident's discharge or termination of services, an assisted living facility must retain a resident's record for at least five years or as otherwise required by state or federal regulations. Arrangements must be made for secure storage and retrieval of resident records if the facility ceases to operate. This MN Requirement is not met as evidenced by: Based on interview and document review, the licensee failed to maintain resident records for at least five years for one of one residents (R1) reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a	0 750		

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0 750	Continued From page 9 resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On March 14, 2023, at 10:55 a.m., surveyor requested administrator (AD)-B to provide R1's fall reports and further incident reports. AD-B failed to provide requested information. On March 21, 2023, at 8:58 a.m., surveyor sent an email to AD-B and requested fall reports and R1's July 2022, service delivery records. AD-B failed to provide records. On March 27, 2023, at 3:41 p.m., surveyor sent AD-B another email requesting R1's July service delivery record. On March 27, 2023, at 5:14 p.m., surveyor received a response email from AD-H indicating R1's service delivery records were on paper, and licensee was unable to locate them. TIME PERIOD OF CORRECTION: Twenty-One (21) Days	0 750		
01760 SS=G	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation	01760		

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01760	Continued From page 10 must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on interview and document review, the licensee staff failed to follow the instructions for administering alternating dosages of a blood thinner (Warfarin) for one of one resident (R1) with record review. The resident had a critically high INR (international normalized ratio) and required emergency medical attention to reduce the risk of bleeding. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R1 admitted to licensee on February 18, 2022, for diagnoses that included presence of heart-valve replacement, ischemic heart disease, emphysema, and diabetes. R1's service plan dated February 18, 2022, indicated the resident received medication	01760		

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	30353	A. BUILDING: _____ B. WING _____	C 03/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ENCORE AT HUGO	5607 150TH STREET NORTH HUGO, MN 55038

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01760	Continued From page 11 management services. R1's progress note dated June 29, 2022, at 1:46 p.m., indicated R1's INR result was critically high at >10.0. Registered nurse (RN)-E sent R1 into the hospital. During an interview on March 21, 2023, at 3:32 p.m., RN-E said she completed an investigation to determine why R1's INR was critically high. RN-E said RN-D failed to ensure the order was correct before approving it. RN-E said the pharmacy entered the order into the elecontric medication administration record (eMAR) system and RN-D failed to verify the medication frequency before approving the new order. R1's eMAR dated June 16, 2022, through June 28, 2022, including the following orders: -Warfarin 2.5 miligrams (mg) tab. Take one tablet by mouth daily on Monday, Wednesday, Friday, and Saturday (5 mg on all other days) the administration time was at 5:00 p.m. Warfarin 5 mg tab. Take one tablet by mouth daily on Sunday, Tues, and Thursday (2.5 mg on all other days) the administration time was at 5:00 p.m. R1's eMAR dated June 16, 2022, through June 28, 2022, indicated staff failed to administer the alternating dosages on specific days as the physician prescribed. Staff who administered the medication failed to read the order correctly, and administered both Warfarin doses daily. Hospital records dated June 29, 2022, at 2:56 p.m., indicated R1 received Warfarin for a mechanical aortic valve and his target INR range was 2.5 through 3.5. The hospital administered 1 mg of oral Vitamin K.	01760		

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01760	Continued From page 12 Licensee's policy titled Medication Administration dated July 2021, indicated the medication aide on duty is responsible for following proper policy and procedure for medication administration. The policy indicated staff would use the "5 rights" when administering medications (right individual, right medication, right dose, right route, and right time). TIME PERIOD FOR CORRECTIOIN: SEVEN (7) DAYS	01760		
02310 SS=G	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on interview and document review, the licensee failed to implement individualized fall interventions and monitoring for bleeding for one of one resident (R1) with records reviewed. R1's returned to licensee with an elevated international normalized ratio (INR) result of 6.22, after a hospital stay for a critical INR (>10). R1 was at risk for falls, and had a fall history. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at an isolated scope (when one or a	02310		

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02310	Continued From page 13 limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). R1 admitted to licensee on February 18, 2022, for diagnoses that included presence of heart-valve replacement, ischemic heart disease, emphysema, diabetes, and dementia. R1's service plan dated February 18, 2022, included assistance with medication administration, mobility, showering, and a daily wellness check. R1's nursing assessment dated February 18, 2022, indicated he was independent with dressing, grooming, and walked independently with a walker. R1's physician history and physical dated May 9, 2022, indicated R1 fell April 27, 2022, and sustained a 3-inch laceration to the right side of his head which required closure with staples. The physician indicated R1 was at high risk for falls. R1's service delivery record dated June 1 though 30, 2022, indicated staff provided safety checks once daily on day shift. The service delivery record failed to identify fall risk or interventions. R1's progress notes dated June 29, 2022, at 1:46 p.m., indicated R1's INR result was critical at >10.0. Registered nurse (RN)-E sent R1 into the hospital. R1's hospital discharge record dated June 30, 2022, indicated R1's INR was elevated at 6.22 when he left the hospital. R1's hospital discharge record indicated he tested positive for coronavirus.	02310		

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02310	Continued From page 14 R1's services failed to include monitoring for signs and symptoms of bleeding and acute infection. R1's change of condition assessment dated July 1, 2022, indicated R1 was at risk for falls, but lacked updated, individualized interventions to reduce fall risk. R1's service plan dated July 1, 2022, indicated staff would provide wellness checks daily to ensure resident safety. The service plan failed to identify further changes or increased services to reduce R1's risk of falls or monitoring for bleeding. R1's progress notes dated July 13, 2022, at 5:08 p.m., indicated R1 had another elevated INR result of 6.16. R1's services again failed to include monitoring for signs and symptoms of bleeding. R1's progress note dated July 20, 2022, at 11:41 a.m., indicated R1 fell in his room and sustained an abrasion to his left elbow. R1's services lacked new fall interventions. During an interview on March 21, 2023, at 3:32 p.m., RN-E said R1 had an extensive fall history. RN-E said R1 was an "autonomous" man who chose not to do a lot of things safely. RN-E said if staff changed fall interventions, or safety checks, interventions would be in R1's service plan. RN-E said unlicensed personnel (ULP) document services provided on paper. RN-E said she was unaware how staff split up the division of duties to provide care.	02310		

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02310	Continued From page 15 The North American Thrombosis Forum website https://thrombosis.org/2020/11/guide-inr-levels/ updated August 9, 2022, indicated a low INR could place a person at risk for blood clots and a high INR could place a person at risk for bleeding. Diet must be monitored while on Warfarin because foods rich in vitamin K can increase INR levels. Licensee's policy titled Assessments, Reviews, and Monitoring dated July 2021, indicated assessments would be used to develop resident's individual service plan to meet their needs and abilities. TIME PERIOD FOR CORRECTION: SEVEN (7) DAYS	02310		