STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355082	A. BUILDING _____ B. WING _____	09/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVE MARIA VILLAGE	501 19TH ST NE JAMESTOWN, ND 58401

(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 000	INITIAL COMMENTS The standard Medicare/Medicaid survey started on 09/17/18 and concluded on 09/201/8.	F 000		
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observation, review of the facility's standard of care, record review, and staff interview, the facility failed to provide reasonable accommodation of needs regarding call lights for 1 of 1 sampled resident (Resident #55) requiring toileting assistance. Failure to place Resident #55's call light within reach may result in discomfort, increased risk for falls, and/or incontinence. Findings include: Review of the facility's Standard of Care document occured on 09/19/18. This document, dated August 2017, stated, " . . . Each of the following is to be provided as routine care by the Nursing Assistants . . . 4. Call light within reach when in room . . . ." Review of Resident #55's medical record occurred on all days of survey. Diagnoses included abnormalities of gait and mobility, Parkinson's disease, and general anxiety	F 558	1. Call light was immediately placed within reach of resident. 2. All residents who use a call light to summon staff assistance have the potential to be affected. 3. All staff has been re-educated on the importance of call lights being placed within resident's reach. This education took place at mandatory CNA meetings on 10-2-18, 10-9-18, and 10-25-18, mandatory nurses meetings on 9-26-18 and 9-27-18, and mandatory all-staff meetings on 10-3-18 and 10-4-18. 4. A QA tool has been developed, and beginning 10-8-18 a random audit of ten residents will be conducted for 10 weeks, and monthly thereafter for 12 months, by QAPI Manager, nurse manager, or designee, to ensure that call lights are being placed within residents' reach.	10/25/18

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

Electronically Signed | 10/05/2018

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F 558	Continued From page 1 disorder. The current care plan stated, " . . . At risk for falls r/t [related to] Parkinson's disease . . . Interventions . . . Keep call light within reach, remind to use and answer promptly . . . needs extensive assist of 1 to use toilet . . . . " The annual Minimum Data Set (MDS), dated 07/23/18, identified the resident as cognitively intact and occassionally incontinent of bowels. Observation on 09/17/18 at 10:24 a.m. showed Resident #55 sleeping in a recliner in her room. Her call light, located on her bed, was not within reach. Observation on 09/18/18 at 8:19 a.m., showed a certified nursing assistant (CNA) (#6) transferred Resident #55 from the wheelchair to her recliner. The CNA left the room and failed to place Resident #55's call light within reach. Approximately 5 minutes later, Resident #55 stated, "I need to use the bathroom." The resident's roommate (Resident # 2) told the resident to put her call light on. Resident #55 stated, "I can't reach my call light and I can't wait." This surveyor activated the call light and after approximately 4-5 minutes a CNA (#7) answered the light and assisted the resident to the bathroom. The resident stated, "It's going to be a mess, I'm already going, I couldn't wait." Observation showed the resident was incontinent with bowel movement (BM) running down both her legs. The CNA (#7) performed partial pericare and called for another CNA (#6) to finish cares. While the CNA (#6) finished pericares, the resident, kept saying, "my back side, my back side needs to be cleaned up." During an interview on the morning of 09/20/18,	F 558	Results will be discussed at the monthly QAPI meeting, with action and follow-up as necessary.	

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F 558	Continued From page 2 an adminisrative nurse (#2) stated the standard of care is for all residents to have their call light within reach.	F 558		
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to	F 623		10/25/18

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F 623	Continued From page 3	F 623		

allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;
(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30 days.

§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:
(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is transferred or discharged;
(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;
(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;
(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and
(vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and

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F 623	Continued From page 4 advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on record review and ombudsman interview, the facility failed to notify the ombudsman of the resident transfers for 3 of 5 sampled residents (Resident #25, #59, and #78) transferred to the hospital. Failure to provide notification of the residents' transfer to the hospital does not allow the ombudsman the opportunity to advocate for the resident, if necessary. Findings include: - Review of Resident #59's medical record occurred on 09/18-20, 2018. The record identified the facility transferred Resident #59 to	F 623	1. Notice of Transfer forms were sent to the Regional LTC Ombudsman for Residents #25, #59, and #78 on 9-27-18. 2. All residents who are transferred to the hospital or otherwise discharged from the facility have the potential to be affected. 3. All nurse managers and nurses were educated to send the Notice of Transfer/Discharge forms to the Regional LTC Ombudsman within one week of transfer or discharge. This education took place at the mandatory nurses meetings on 9-26-18 and 9-27-18. Instructions	

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F 623	Continued From page 5 the emergency room on 07/19/18 at 6:25 p.m. On 07/20/18 at 3:00 a.m. the facility received a call from the local hospital informing them of Resident #59's admission. The record contained a notice of transfer form, but lacked evidence the facility notified the ombudsman of the transfer. - Review of Resident #25's medical record occurred on September 18-19, 2018. The record identified Resident #25 went to the clinic on 06/20/18 and was later admitted to the hospital. The record contained a notice of transfer form, but lacked evidence the facility notified the ombudsman of the transfer. - Review of Resident #78's medical record occurred on September 18-19, 2018. The record identified the facility transferred Resident #78 to the hospital on 02/16/18. The record contained a notice of transfer form, but lacked evidence the facility notified the ombudsman of the transfer. An interview with the regional ombudsman (#4) occurred on 09/20/18 at 11:45 a.m. The ombudsman stated he expected staff to notify him within two weeks of a resident's transfer to the hospital. An interview with the state ombudsman (#5) occurred on 09/20/18 at 11:55 a.m. The ombudsman stated she would expect staff to notify the regional ombudsman within one to two weeks of a resident's transfer to the hospital in order for the ombudsman to promptly advocate for the resident if necessary.	F 623	have been added to the nurses Transfer/Discharge Checklist. 4. A QA tool has been developed, and beginning 10-8-18 an audit of all residents transferred or discharged from of the facility will be completed by QAPI Manager, nurse manager or designee, to ensure that transfer/discharge forms are being consistently sent to the Regional Ombudsman. This audit will be completed ongoing for twelve months. The results will be discussed at the monthly QAPI meeting, with action and follow-up as necessary.	
F 644 SS=D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2)	F 644		10/25/18

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F 644	Continued From page 6 §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is not met as evidenced by: Based on record review, review of the North Dakota Provider Manual for Preadmission Screening and Resident Review (PASARR) and Level of Care Screening Procedures for Long Term Care Services, and staff interview, the facility failed to complete a status change assessment for 1 of 4 sampled residents (Resident #46) with a newly diagnosed mental illness. Failure to complete a change in status assessment may result in the delivery of care and services that are inconsistent with resident's needs. Findings include: The North Dakota PASARR Provider Manual page 13 states, ". . . Change in Status Process . .	F 644	1. A PASARR screening was completed for Resident #46 on 9-20-18. 2. All residents who have a newly diagnosed mental illness or change in status have the potential to be affected. 3. All nurses and nurse managers have been educated to notify the Admissions Director of any newly diagnosed mental illness that would require a PASARR screening. This education took place at mandatory nurses meetings held 9-26-18 and 9-27-18. The Admissions Director and/or designee will complete the PASARR screening as indicated.	

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F 644	Continued From page 7 . Whenever the following events occur, nursing facility staff must contact Ascend [contracted service provider for screening process] to update the Level I screen for determination of whether a first time or updated Level II evaluation must be performed. These situations suggest that a significant change in status has occurred: . . . If an individual with MI, ID, and/or RC (mental illness, intellectual disability, and conditions related to intellectual disability [referred to in regulatory language as related conditions or RC]) was not identified at the Level I screen process, and that condition later emerged or was discovered. . . ." Review of Resident #46's medical record occurred on September 18-19, 2018. The record showed Resident #46 went to the emergency room on 11/26/16. The resident returned with a new diagnosis of senile psychosis with behavioral disturbance and dementia. The record lacked evidence of an updated Level I screening/change in status assessment since this diagnosis. During an interview on the afternoon of 09/19/18, a supervisory nurse (#1) agreed Resident #46 should have had a Level I assessment completed after the new diagnosis.	F 644	4. A QA tool auditing all residents has been developed to ensure that a new PASARR screening has been completed for any resident with a new or changed diagnosis or changed mental status. Beginning 10-8-18 an audit of all residents will be completed to ensure that any resident with a new or changed diagnosis requiring a PASARR screen has had one completed. The audit will be completed every two weeks by QAPI Manager, nurse manager or designee, for twelve months. The results will be discussed at monthly QAPI committee meetings with action and follow-up as necessary.	
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced	F 658		10/25/18

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F 658	Continued From page 8 by: Based on observation, review of professional reference, review of facility policy, record review and staff interview, the facility failed to administer medications in accordance with acceptable standards of practice during 1 of 1 random observation in the dining room. Failure of nursing to assure the resident received the medication safely may result in adverse effects for the resident. Findings include: Review of facility policy titled "Medication Administration . . ." occurred on 09/20/18. This policy revised August 2018 stated, " . . . The Primary Care Nurse . . . ensures that the resident receives the drug as prescribed . . . To distribute medications as ordered Nursing: . . . ascertains that the resident has swallowed the medications . . . records the administration of medication after it is given . . . " Kozier & Erb's "Fundamentals of Nursing, Concepts, Process and Practice," 10th Edition, 2016, pages 870, stated " . . . Administering oral medications: . . . stay with the client until all medications have been swallowed . . . the nurse must see the client swallow the medication before the drug administration can be recorded . . . the nurse may need to check the clients mouth to ensure that the medication was swallowed and not hidden . . . if time of administration differs from prescribed time . . . explain reason in nursing notes . . ." Observation on 09/17/18 at 11:55 a.m. showed a staff nurse (#3) administered a small white	F 658	1. For Resident #10, the over-the-counter Tylenol Extended Release tablets were changed to a crushable form on 9-21-18. 2. All residents who receive medications have the potential to be affected. 3. All nurses and medication aides have been re-educated on the importance of ensuring that all residents swallow their medications. This education was done at the mandatory nurses meetings on 9-26-18 and 9-27-18. 4. A QA tool has been developed, and beginning 10-8-18, an audit of ten residents will be performed weekly for ten weeks, and monthly thereafter for twelve months, by QAPI Manager, nurse manager, or designee to ensure that nurses are consistently observing and assuring that residents are swallowing their medications. Results will be discussed at the monthly QAPI meetings, with action and follow-up as necessary.	

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F 658	Continued From page 9 oblong tablet to Resident #10 and walked away. A few minutes later, observation showed Resident #10 took the tablet from her mouth and set it on a napkin on the table. Observation at approximately 12:15 p.m., showed the resident move the tablet from the napkin to the dinner plate. Review of Resident #10's medical record occurred on 09/18/18. The resident's medications included Tylenol Arthritis Pain extended release 650 milligrams (mg), 1 tablet three times a day for pain. Review of the medication administration record (MAR) dated 09/17/18 at 12:00 p.m. showed the staff nurse (#3) documented the medication was spit out by Resident #10. An interview occurred with the staff nurse (#3) on 09/17/18 at 12:37 p.m. When asked if Resident #10 took the 12:00 p.m. medication, the nurse (#3) confirmed yes, she believed the medication was swallowed. Observation showed the nurse (#3) then went to the table where Resident #10 sat, found the tablet on the resident's plate, spooned the tablet and administered it to Resident #10. The nurse (#3) stated Resident #10 often pockets meds and she believed the med was swallowed at the first administration. During an interview with an administrative nurse (#2) on the morning of 09/20/18, the nurse confirmed the need for staff to ensure Resident #10 ingest medications when administered. Staff failed to assure the resident had swallowed the medication.	F 658		
F 676 SS=D	Activities Daily Living (ADLs)/Mntn Abilities CFR(s): 483.24(a)(1)(b)(1)-(5)(i)-(iii)	F 676		10/25/18

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F 676	Continued From page 10 §483.24(a) Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility must provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. This includes the facility ensuring that: §483.24(a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section ... §483.24(b) Activities of daily living. The facility must provide care and services in accordance with paragraph (a) for the following activities of daily living: §483.24(b)(1) Hygiene -bathing, dressing, grooming, and oral care, §483.24(b)(2) Mobility-transfer and ambulation, including walking, §483.24(b)(3) Elimination-toileting, §483.24(b)(4) Dining-eating, including meals and snacks, §483.24(b)(5) Communication, including (i) Speech, (ii) Language, (iii) Other functional communication systems. This REQUIREMENT is not met as evidenced by:	F 676		

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F 676	Continued From page 11 Based on observation, record review, and staff interview, the facility staff failed to provide the necessary assistance regarding supervision with eating for 1 of 3 residents observed (Resident #10) who require assistance. Failure to provide Resident #10 with assistance and supervision at mealtime could place the resident at risk for weight loss, insufficient fluid intake, and potential complications related to inadequate nutrition and hydration that can diminish quality of life. Findings include: Review of Resident #10's medical record occurred on all days of survey. The care plan included: "Focus: Original date 03/31/2015, updated 10/18/2017 . . . has an ADL self care performance defecit related to (r/t) dementia . . . interventions . . . eating: . . . requires supervision . . . extensive assist . . . " Observation on 09/17/18 at 11:55 a.m. showed the resident sitting at a dining room table eating with her fingers. There was no silverware at the table for her to use. Observation continued throughout the meal to 12:37 p.m. as Resident #10 continued to eat her meal with her fingers, no utensils used, licking her fingers after her bites of food. The resident did not drink any of the fluids in her cups/glasses during this time. Observation on 09/18/18 at 12:02 p.m. showed Resident #10 at the dining room table eating apple pie, green beans, chopped steak, mashed potatoes with her fingers, licking her fingers in between bites of food. No utensils were available and no staff offered assistance to the resident. At 12:09 p.m., a staff nurse (#3) noticed Resident	F 676	1. Neighborhood staff were instructed to provide the appropriate level of assistance to Resident #10 with all meals, as she allows, on 9-21-18. 2. All residents requiring assistance with eating and drinking have the potential to be affected. 3. Staff have been re-educated on the necessity of assisting residents who are unable to eat or drink independently, in accordance with their resident assessment and care plan. This education was completed at mandatory CNA meetings on 10-2-18, 10-9-18, and 10-25-18, and mandatory nurses meetings on 9-26-18 and 9-27-18, and all-staff meetings on 10-3-18 and 10-4-18. 4. A QA tool has been developed, and beginning 10-8-18, a random audit of 10 residents will be performed by QAPI Manager, nurse manager, or designee, weekly for ten weeks, then monthly thereafter for twelve months, to assure that all residents in need of assistance with eating or drinking are receiving the appropriate level of assistance. The results will be discussed at the monthly QAPI meetings, with action and follow-up as necessary.	

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	355082	A. BUILDING _____ B. WING _____	09/20/2018

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F 676	Continued From page 12 #10 at the table eating her lunch with her fingers, unsupervised, and motioned for staff to bring a spoon and assist the resident with eating. An interview occurred with an administrative nurse (#2), on the morning of 09/20/18, regarding observations with Resident #10 eating meals in the dining room with her fingers. The nurse stated this is not what they expect and the resident is care planned to be assisted.	F 676		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of	F 755		10/25/18

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F 755	Continued From page 13 receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy, record review, and staff interview, the facility failed to ensure a medication cartridge was labeled with the correct dose for 1 of 2 medication carts observed. Failure to correctly label and provide accurate doses of medications may result in adverse side effects on Resident #47 and other residents in the facility. Findings include: Review of facility policy titled "Medication Ordering and Delivery from Pharmacy" occurred on 09/20/18. This policy, updated August 2017, stated, ". . . When a change in an order occurs for a medication . . . [facility] will assume the responsibility for ordering the medications and the provider is responsible for delivery . . . medication/strength/time . . . special directions or changes for administering medication . . . any precautions . . . any other pertinent information is given . . ." Observation on 09/19/18 at 4:28 p.m. of a medication cart showed a medication cartridge of Resident #47's Warfarin with label instructions stating, "Warfarin (Coumadin) take 1/2 tab or 2.5 mg (milligrams) on Monday and take 1 tablet (5 mg) all other days."	F 755	1. For Resident #47, the card was sent to pharmacy on 9-19-18 to be relabeled to reflect correct dose. 2. All residents who receive prescription medications have the potential to be affected. 3. Nurses and medication aides have been re-educated to ensure that the medication label, eMAR, and the physician□s orders all match. If a discrepancy is noted, the order will be clarified, and the medication will be returned to the pharmacy for the appropriate correction. This education took place at the mandatory nurses meetings on 9-26-18 and 9-27-18, and at the mandatory all-staff meetings on 10-3-18 and 10-4-18. 4. A QA tool has been developed, and beginning 10-8-2018, a random audit of ten medication cards will be completed by QAPI Manager, nurse manager, or designee, weekly for ten weeks, then monthly thereafter for twelve months. Specifically, the audit will ensure that the medication label, eMAR, and physician	

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F 755	Continued From page 14 Review of Resident #47's medication administration record (MAR) on 09/20/18 identified, "Give Coumadin 2.5 mg on Monday,Wednesday and Friday, and Coumadin 5 mg on Sunday, Tuesday, Thursday and Saturday." The medication cartridge contained twelve 5 mg tablets and one 2.5 mg tablet in the Monday slot. Review of Resident #47's medical record occurred on 09/20/18. The record identified physician orders, dated 09/11/18 as: Coumadin tablet 2.5 mg by mouth one time a day every Monday, Wednesday and Friday and Coumadin tablet 5 mg by mouth one time a day every Sunday, Tuesday, Thursday and Saturday. The MAR and the physician's order failed to match the label on the medication cartridge. Interview with a staff nurse (#9) occurred on 09/19/18 at 5:20 p.m. When asked if there were other Coumadin cartridges for Resident #47 in the medication cart or room the nurse stated there were none. The nurse (#9) checked all the medication storage areas and found no other Coumadin for Resident #47. The nurse (#9) confirmed the MAR had the correct Coumadin dose and the Coumadin medication cartridge had the incorrect dosage and labeling. Interview on 09/19/18 at 05:25 p.m. with an administrative nurse (#8) confirmed the physician's orders as noted on the MAR were correct and the label on the medication cartridge was incorrect. On 09/20/18 at 11:15 a.m., an interview occurred	F 755	orders all match. If a discrepancy is noted, the medication will be returned to the pharmacy immediately for correction. Results will be discussed at monthly QAPI meetings, with action and follow-up as necessary.	

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F 755	Continued From page 15 with a pharmacist (#10) regarding Resident #47's Coumadin physician's orders and medication cartridges. The pharmacist verified they received an order for Coumadin on 09/17/18 from Resident #47's physician which stated Coumadin 2.5 mg Monday, Wednesday and Friday and Coumadin 5 mg all other days. The pharmacist (#10) stated the medication dose and label previously sent to the facility and the cartridge they were using for Resident #47 was an error. The pharmacist also stated the facility called on 09/19/18 to request the correct Coumadin medication dose and label for Resident #47 and it was sent to the facility on that day.	F 755		