

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155784	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  03/19/2015
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NAME OF PROVIDER OR SUPPLIER  MICHIANA HEALTH AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1420 E DOUGLAS RD MISHAWAKA, IN 46545
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(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
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F 000  Bldg. 00	<p>This visit was for the Investigation of Complaints IN00168371, IN00168373 and IN00168816.</p> <p>Complaint IN00168371 - Substantiated. Federal/State deficiencies related to the allegations are cited at F282.</p> <p>Complaint IN00168373 - Substantiated. Federal/State deficiencies related to the allegations are cited at F282.</p> <p>Complaint IN00168816 - Substantiated. Federal/State deficiencies related to the allegations are cited at F282 and F329.</p> <p>Survey dates: March 18 and 19, 2015</p> <p>Facility number: 012329 Provider number: 155784 AIM number: 201002500</p> <p>Survey team: Honey Kuhn, RN</p> <p>Census bed type: SNF/NF: 76 Total: 76</p> <p>Census payor source: Medicare: 8 Medicaid: 40</p>	F 000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE \_\_\_\_\_ TITLE \_\_\_\_\_ (X6) DATE \_\_\_\_\_

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 282 SS=E Bldg. 00	<p>Other: 28 Total: 76</p> <p>Sample: 4</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality Review completed on March 24, 2015, by Brenda Meredith, RN.</p> <p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on record review and interviews, the facility failed to ensure a resident admitted following knee replacement surgery received CPM (Continuous Passive Motion Machine) as ordered for therapy. (Resident "E") The facility further failed to ensure medications were ordered, received and administered timely following admission for 4 of 4</p>	F 282	<p>This plan of correction constitutes this facility's written allegation of compliance for the deficiencies cited. The submission of this plan of correction is not an admission of or agreement with the deficiencies or conclusions contained in the Indiana Department of Health's inspection report. Michiana Health and Rehabilitation Center requests consideration for a desk review of this plan of correction.</p> <p>F 282 E</p>	04/17/2015

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	<p>residents reviewed for medication orders. (Resident "B", Resident "C", Resident "D" and Resident "E") This deficiency affected 4 of 4 residents reviewed for physician orders.</p> <p>Finding includes:</p> <p>1. The record of Resident "E" was reviewed on 03/18/15 at 1:00 p.m. Resident "E" was admitted to the facility on 02/19/15, with diagnoses including, but not limited to, atrial fibrillation, obesity, coronary heart disease, thyroid disease without goiter, and (L) TKA (Left Total Knee Arthroplasty: knee replacement). Resident "E" was discharged home with family on 02/21/15.</p> <p>The ACF (Acute Care Facility hospital) transfer form, signed and dated 02/19/15 at 2:30 p.m., indicated: "Therapy:...Special Therapy orders: CPM 0-90* [degrees] TID [3 times daily] X 2 hrs [hours] for 3 wks [weeks], increase daily."</p> <p>A "WORK ORDER" request from a medical equipment supplier, dated 02/18/15 at 1:56 p.m., indicated a CPM machine was ordered for Resident "E." The form was initialed by the medical equipment supplier and indicated, "...All products were</p>		<p>Resident's D and E no longer reside at the center.</p> <p>Resident's B and C's orders were clarified and residents are currently receiving medication and care in accordance to physician orders per resident specific care plan.</p> <p>All residents who reside at this facility have potential to be affected. Residents residing in the facility will be addressed by following policy and procedure and re-educated and/or disciplinary action of employees who are found in violation.</p> <p>Resident's charts have been reviewed to ensure residents are receiving medications and CPM's applied/ given in accordance to physician orders by April 6, 2015. Facility licensed nurses will be educated by DON/ designee on physician orders; admission processes and medication pass to ensure compliance.</p> <p>Unit Managers and/or designee will complete audits on unit charts daily for 2 weeks, then 3 times a week for 2 weeks then weekly for 8 weeks then monthly for 3 months. Trends will be reviewed in QA monthly times 3 months and quarterly thereafter to determine further education and/or monitoring needs. Audits will be turned into and monitored by the DON for completion. Identified non-compliance will result in one to one re-education up to and including termination. Any identified trends will be</p>	

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	<p>field tested and function without defect." The area for the receiving facility to initial was blank.</p> <p>The TAR (Treatment Administration Recor)], dated 02/2015, indicated: "02/19/15 CPM 0-90* TID X 2* [hours] X 3 weeks, increase daily." The CPM treatment record was initialed only one time, on 3rd shift, on 2/21/15 for 10:00 p.m. - 6:00 a.m. The record indicated the resident was discharge before the 3rd shift on 02/21/15.</p> <p>The "Progress Notes" indicated the Resident "E" arrived at the facility on 2/19/15 at 6:45 p.m. There was no documentation in regard to the CPM until:</p> <p>"02/20/15 10:40 p.m....CPM machine not working. Called company and was told they would be here tonight. No one has shown up as of now. Confirmation [?] c/o [complained/of] CPM not fixed and stated she will be leaving the facility tomorrow...."</p> <p>"02/21/15 [untimed] upon arriving to this 7 a.m. - 3 p.m. shift writer was told in report pt. [patient] was extremely unhnappy with her care...issues being...5) and no one called about the CPM machine not</p>		<p>forwarded to administrator for review and presented to QA to determine further educational needs.</p> <p>Date of compliance will be April 17, 2015.</p>				

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	<p>working. Writer attempted to tell pt. these were all issues we could work through but pt. stated she was going home regardless. Writer then came in contact with [medical equipment supplier] who fixed the machine &amp; stated she would be able to take it home....Pt. discharged with orders...."</p> <p>The Director of Nursing Services (DNS) was interviewed on 03/19/15 at 10:30 a.m. The DNS was unaware the documentation indicated the resident did not receive CPM treatments during her stay as ordered.</p> <p>2. The record of Resident "B" was reviewed on 03/18/15 at 11:10 a.m. Resident "B" was admitted to the facility on 03/13/15 with diagnoses including, but not limited to, hypertension (high blood pressure) headaches, hypertension, depression, acute MI (Myocardial Infarct: heart attack), esophageal reflux, urinary incontinence and S/P (Status/Post) fracture around prosthetic joint 2 weeks after (L) (left) femur surgery. The resident had a PICC (Percutaneous Inserted Central Catheter: an Intravenous (IV) catheter inserted for prolonged IV therapy such as antibiotics.)</p>			

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	<p>The Discharge Medication Orders from the ACF (Acute Care Facility: hospital) indicated medications for Resident "B" included, but were not limited to:</p> <p>*Aztreonam (antibiotic) 2 GM (Gram) IV (Intravenous) piggyback every 8 hours for 30 days *Metronidazol (antibiotic) 500 mg [milligram] oral tablet: 1 tab [tablet] by mouth, 3 times a day for 14 days.</p> <p>The MAR (Medication Administration Record), dated 03/2015, indicated, between 03/13/15 to the review on 03/18/15, Resident "B" had not received the following medication as ordered:</p> <p>*Aztreonam 2 Gm IV was not given on 03/14/15 at 10:00 p.m. and 03/15/15 at 2:00 p.m. *Metronidazol 500 mg was not given on 03/17/15 at 12:00 p.m.</p> <p>3. The record of Resident "C" was reviewed on 03/18/15 at 10:10 a.m. Resident "C" was admitted to the facility, on 01/12/15 at 7:45 p.m., with diagnoses including, but not limited to, closed (R) (right) ankle fracture, muscle weakness, hypertension, GERD (Gastro-Esophageal Reflux Disease) and difficult ambulation.</p>			

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	<p>The Discharge Medication Orders from the ACF (Acute Care Facility: hospital) transfer, dated 01/12/2015, included but was not limited to the medications:</p> <p>*Warfarin (blood thinner) 2 mg tablet: 1 tab [tablet] daily *Metoprolol (hypertension) 50 mg: 1 tablet twice a day.</p> <p>The MAR (Medication Administration Record), dated 01/2015, indicated the Resident "B" did not receive the following medications as ordered:</p> <p>*Warfarin 2.0 mg tab (tablet) PO (by mouth) daily at 8:00 p.m. was not given on 01/12/15, 01/13/15 and 01/15/15. *Metoprolol 50 mg, 1 tablet orally 2 times a day was not given on 01/12/15 at 8:00 p.m. and 01/13/15 8:00 p.m.</p> <p>4. The record of Resident "D" was reviewed on 03/18/15 at 1:40 p.m. Resident "D" was admitted to the facility on 01/20/15 and discharged home on 01/21/15. The resident's diagnoses included, but were no limited to, (R) TKA (Right Total Knee Arthroplasty: knee replacement), hypertension, hypercholesterol</p>			

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	<p>(increased cholesterol), GERD (Gastro-Esophageal Reflux Disease), and hypothyroidism (low thyroid).</p> <p>The "Progress Notes" indicated Resident "D" admitted from [name] hospital on 01/20/15 at 6:15 p.m.</p> <p>The Discharge Medication Orders from the ACF (Acute Care Facility: hospital) transfer, dated 01/20/2015, included but was not limited to the medications:</p> <p>*Enoxaparin (blood thinner) 40 mg [milligram]/0.4 ml (milliliter)...subcutaneous [into subcutaneous tissue] every 12 hours            *Gabapentin (anti-seizure/neuralgia) 100 mg TID (3 times a day)            *Sertraline (depression) 50 mg...1 tab...every bedtime            *Septra DS (Double Strength) (urinary tract infection) 1 tab...BID (twice daily) for 10 days            *Oxycontin (pain) 20 mg 1 tab po (per os: by mouth) BID.</p> <p>The MAR (Medication Administration Record), dated 01/2015, indicated Resident "D" did not receive medications as ordered:</p> <p>*Enoxaparin 40 mg/0.4 ml BID was not given on 01/20/15 at 9:00 p.m.</p>			

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	<p>*Gabapentin 100 mg TID was not given on 01/20/15 at 8:00 p.m.</p> <p>*Sertraline 5 mg bedtime daily was not given on 1/20/15 at 8:00 p.m.</p> <p>*Septra DS BID was not given on 01/20/15 at 8:00 p.m.</p> <p>*Oxycibntin 20 mg BID was not given on 01/20/15 at 8:00 p.m.</p> <p>5. The record of Resident "E" was reviewed on 03/18/15 at 1:00 p.m. Resident "E" was admitted to the facility, on 02/19/15, with diagnoses including, but not limited to, atrial fibrillation, obesity, coronary heart disease, thyroid disease without goiter and (L) TKA (Left Total Knee Arthroplasty: knee replacement). Resident "E" was discharged home with family on 02/21/15.</p> <p>The Progress Note" indicated the resident was arrived at the facility on 02/19/15 at 4:30 p.m.</p> <p>The Discharge Medication Orders from the ACF (Acute Care Facility: hospital) transfer, dated 02/19/15, included but was not limited to the medications:</p> <p>*Olmesartan (high blood pressure) 20 mg give 2 tablets for total of 40 mg daily</p> <p>*Xanelto (blood thinner) 10 mg QD</p>			

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	<p>(every day).</p> <p>The MAR (Medication Administration Record), dated 02/2015, indicated medications for Resident "E" were not started until 02/20/15. The resident did not receive medications as ordered:</p> <p>*Olmesartan 20 mg (2) tabs daily was not given on 01/20/15 at 8:00 a.m. *Xanelto 10 mg QD was not given on 01/19/15 at 8:00 p.m. and 01/20/15 at 8:00 p.m.</p> <p>Confidential interviews with residents were completed during the survey. Two of three residents interviewed indicated they did not receive their medications timely upon admission and had missed medications during their stay.</p> <p>LPN #5 was interviewed on 03/18/15 at 11:00 a.m. LPN #5 indicated being unaware any residents had missed medication dosages. LPN #5 indicated most of the residents were alert and oriented and no concerns had been expressed.</p> <p>LPN #2 was interviewed on 03/18/15 at 2:30 p.m. LPN #2 was queried if nurses checked when medications were last given prior to a resident's</p>			

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	<p>admission to the facility. LPN #2 indicated the nurse should check during admission but was uncertain if it was part of the facility policy. LPN#2 indicated the facility pharmacy provides medication delivery within a 4 hour window of receiving orders. The nurse was unaware any residents did not receive medications on the day of admission.</p> <p>The DNS (Director Nursing Services) was interviewed on 03/19/15 at 10:00 a.m. The DNS indicated being unaware residents did not receive their medications upon admission. At this time, the DNS provided a copy of the current policy and procedure, titled, "Medication Administration" dated April 2005. The policy and procedure indicated: "Policy...strives to provide safe administration of all medications. The licensed nurse and/or assistant will administer medication according to State specific regulation... 8. Read the Medication Administration Record (MAR) for the ordered medication, dose, dosage form, route, and time... 10. Verify the pharmacy prescription ... a. If there is a discrepancy, check the original physician's order and notify</p>			

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	<p>the pharmacy. Do not give the medication until clarified..."</p> <p>The facility did not provide a policy or procedure for physician orders or documentation upon request.</p> <p>This Federal tag relates to Complaints IN00168371, IN00168373 and IN00168816.</p> <p>3.1-35(g)(2)</p>			

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F 329 SS=D Bldg. 00	<p>483.25(I) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS</p> <p>Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>Based on record review and interviews, the facility failed to clarify medication orders for dosage and monitoring for 1 of 4 residents receiving a blood thinners in a sample of 4. (Resident "C")</p> <p>Finding includes:</p> <p>The record of Resident "C" was reviewed on 03/18/15 at 10:10 a.m. Resident "C" was admitted to the facility, on 01/12/15, with diagnoses including, but not limited to, closed (R) (right) ankle fracture,</p>	F 329	<p>F 329 D Resident C's medication orders were clarified to ensure orders and lab testing for anticoagulant therapy was being monitored appropriately per physician orders.</p> <p>All residents who reside at this facility have potential to be affected. Residents residing in the facility will be addressed by following policy and procedure and re-educated and/or disciplinary action of employees who are found in violation.</p> <p>Resident's anticoagulant orders</p>	04/17/2015

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	<p>muscle weakness, hypertension, GERD (Gastro-Esophageal Reflux Disease) and difficult ambulation.</p> <p>The "Progress Note" indicated the resident arrived at the facility on 01/12/15 at 7:45 p.m.</p> <p>The Discharge Medication Orders from the ACF (Acute Care Facility: hospital), dated 01/12/2015, included but was not limited to the medication: Warfarin (anticoagulant: blood thinner) 2 mg tablet: 1 tab (tablet) daily. The discharge instructions indicated the last dose was given 01/11/15 at 5:22 p.m.</p> <p>The MAR (Medication Administration Record), dated 01/2015, indicated the Resident "B" did not receive Warfarin medication on 01/12/15, 01/13/15 and 01/15/15.</p> <p>The Physician Orders indicated: 02/13/15 -- "PT/INR [Protime/International Ratio: a test to measure coagulation: blood clotting for dosage adjustment] q [every] M [Monday] - Th [Thursday] - reports to [Resident's Physician's name]."</p> <p>02/20/15 -- "1) Cont [continue] Coumadin 2.5 mg [milligram] Po [per os: by mouth] daily. 2) Recheck PT/INR on</p>		<p>have been clarified to ensure orders and monitoring for anticoagulant therapy are in accordance to physician orders by April 6, 2015.</p> <p>Facility licensed nurses will be educated by DON/ designee on anticoagulant therapy process and physician orders.</p> <p>Unit Managers and/or designee will complete audits on unit charts daily for 2 weeks, then 3 times a week for 2 weeks then weekly for 8 weeks then monthly for 3 months. Trends will be reviewed in QA monthly times 3 months and quarterly thereafter to determine further education and/or monitoring needs. Audits will be turned into and monitored by the DON for completion.</p> <p>Identified non-compliance will result in one to one re-education up to and including termination. Any identified trends will be forwarded to administrator for review and presented to QA to determine further educational needs.</p> <p>Date of compliance will be April 17, 2015.</p>				

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	<p>2/26 [Thursday]." The order noted the name of the facility physician/Medical Director. The record did not contain a PT/INR for 02/26/15.</p> <p>02/20/15 -- "Order Clarification: Medical Director [physician's name] to monitor Coumadin [Warfarin] therapy."</p> <p>03/12/15 -- "[Thursday] Increase Coumadin to 3 mg PO daily. Check PT/INR in 1 week."</p> <p>The record did not indicate an order to discontinue the twice weekly PT/INR's as originally ordered. The lab order, as written, indicated Resident "C" did not have PT/INRs drawn: Monday,02/23/15; Thursday, 02/26/15; Monday, 03/02/15; Thursday, 03/05/15; and, Monday, 03/16/15.</p> <p>The PT/INR labs indicated: "03/09/15 collected 12:00 p.m." A handwritten note indicated, "03/11/15 currently taking Coumadin 3 mg Po qd." Another note, written in another hand, indicated, "3/12/15 ^ [increase sign] 4 mg qd. check PT/INR in 1 wk [week]."</p> <p>The PT/INR results from 03/9/15 were addressed for dosage 3 days later, on 03/12/15. The lab drawn 03/09/15, result was received 3/10/15. On 3/11/15, the</p>			

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	<p>resident was noted to be receiving Coumadin 3.0 mg, while the MAR documentation indicated the resident as receiving Coumadin 2.5 mg. The note on the lab result, dated 03/12/15, indicated a dosage increase to Coumadin 4 mg.</p> <p>Review of the resident's "COUMADIN PT/INR LOG," indicated the documentation was incomplete or did not correlate with the labs or dosages.</p> <p>LPN #2 was interviewed on 03/18/15 at 2:30 p.m. LPN #2 was unaware of the discrepancies in regards to the PT/INRs and Coumadin dosages. LPN #2 indicated the Coumadin Log was not accurate.</p> <p>The Director of Nursing Services (DNS) was interviewed on 03/19/15 at 10:00 a.m. in regards to the documentation and noting the discrepancies. The DNS indicated the admission process did not include staff verifying when last dosages of medications were administered. The DNS indicated the discrepancy between the MARs and the PT/INR did not clarify what the resident was taking. The DNS indicated the Coumadin Log was not accurate.</p> <p>On 03/19/15 at 10:30 a.m., the DNS provided the facility's policy and</p>			

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	<p>procedure titled, "Coumadin (Warfarin) and Other Anticoagulant Medication: 03/2015" which indicated the following: "POLICY: Extended Health Centers monitor residents receiving Coumadin (warfarin) therapy using the PT/INR Log, PT/INR lab monitoring is used for residents receiving Coumadin...</p> <p>PROCEDURE...</p> <ol style="list-style-type: none"> <li>1. Obtain order and document on Physician Telephone Order sheet. Order should include:               <ol style="list-style-type: none"> <li>a. Diagnosis for use of Coumadin. (warfarin)</li> <li>b. Warfarin dosage and frequency of administration</li> <li>c. Frequency of lab draws for PT and/or INR testing,...</li> </ol> </li> <li>2. Document the medication order on the Coumadin Medication Administration Record (MAR) instead of the monthly MAR&gt;</li> <li>3. Initiate the Coumadin (PT/INR) Log and place it in the MAR&gt;</li> <li>4. Document the lab orders for PT and/or INR testing on the Coumadin.(PT/INR) Log Order Form...."</li> </ol> <p>The Policy &amp; Procedure did note address timeliness of lab results or notification of physician.</p>			

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	This Federal tag relates to Complaint IN00168816.  3.1-48(a)(3)			