

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155494	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/24/2013
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NAME OF PROVIDER OR SUPPLIER WATERS OF SCOTTSBURG THE	STREET ADDRESS, CITY, STATE, ZIP CODE 1350 N TODD DR SCOTTSBURG, IN 47170
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F000000	<p>This visit was for the Investigation of Complaint IN00131531, Complaint IN00132660, Complaint IN00133952, Complaint IN00135486, and Complaint IN00136238.</p> <p>Complaint IN00131531 - Substantiated. Federal/State deficiencies related to the allegations are cited at F329.</p> <p>Complaint IN00132660 - Substantiated. Federal/State deficiencies related to the allegations are cited at F315.</p> <p>Complaint IN00133952 - Substantiated. No deficiencies related to the allegations are cited.</p> <p>Complaint IN00135486 - Substantiated. Federal/State deficiencies related to the allegations are cited at F322.</p> <p>Complaint IN00136238 - Substantiated. Federal/State deficiencies related to the allegations are cited at F225.</p> <p>Survey Dates: September 11, 12, 13, 16, 17, 23, & 24, 2013</p>	F000000	Preparation and/or execution of this plan of correction in general, or this corrective action in particular, does not constitute an admission of agreement by this facility of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction and specific corrective actions are prepared and/or executed in compliance with State and Federal Laws.	

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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	<p>Facility number: 000478 Provider number: 155494 AIM number: 100290430</p> <p>Survey team: Gwen Pumphrey, RN-TC</p> <p>Census Bed Type: SNF/NF: 77 Total: 77</p> <p>Census Payor Type: Medicare: 7 Medicaid: 63 Private: 3 Other: 4 Total: 77</p> <p>Sample: 31</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2</p> <p>Quality Review completed on 10/4/2013 by Cheryl Fielden, RN</p>				

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F000225 SS=D	<p>483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS</p> <p>The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>Based on interview, and record</p>	F000225	Preparation and/or execution of	10/21/2013			

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	<p>review, the facility failed to thoroughly investigate an injury of unknown origin. This deficient practice affected 1 of 3 residents reviewed for abuse.(Resident #K)</p> <p>Findings include:</p> <p>An observation of the photograph of Resident #K's injury was provided on 9/12/13 at 9:30a.m., it indicated the resident had bruising to his left eye. This photograph was sent to the Indiana State Departement of Health.</p> <p>The resident was observed in the activity room on 9/12/13 at 10:00a.m. with no bruising to his eye.</p> <p>The Administrator provided a copy of the incident report related to Resident #K's injury. Review of the incident report filed on 9/9/13 with the Indiana State Department of Health indicated on 9/8/13 the resident sustained an injury to his eye around 5:00 a.m. Resident #K reported to staff "a guy come in here and beat me up after work". The report included an in house reporting tool, statements from three staff and an initial interview from the resident.</p> <p>Review of the clinical record on 9/12/13 at 11:00 a.m., indicated</p>		<p>this plan of correction in general, or this corrective action in particular, does not constitute an admission of agreement by this facility of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction and specific corrective actions are prepared and/or executed in compliance with State and Federal Laws. F225- INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS** THE WATERS OF SCOTTSBURG RESPECTFULLY REQUESTS PAPER/DESK COMPLIANCE BE GRANTED FOR THIS CITATIONWhat corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?It is the policy of this facility to promptly and thoroughly investigate any allegations of abuse or misconduct involving residents to ensure safety and care needs are met at all times. It is also the policy of this facility to document all relevant issues related to the incident in question, regardless of the outcome, including, but not limited to, follow up actions and documentation of resident dispositions. This facility will immediately report these incidents to their physician and to their families, if applicable. Resident K's care plan was updated to reflect the appropriate follow up for psychosocial wellbeing, as well as for the risk</p>		

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	<p>Resident #K was admitted on on 1/15/09. The resident had diagnoses including but not limited to, dementia, diabetes, congestive heart failure, hypertension, and osteoarthritis.</p> <p>Review of the Minimum Data Set (MDS) Assessment dated 7/23/13 indicated the resident had a BIMS (Brief Interview for Mental Status) score of 5. This score indicates the resident had some cognitive impairment.</p> <p>The care plan was reviewed on 9/12/13 at 11:00 a.m. The care plan lacked documentation related to the incident and included but was not limited to, bruising, monitoring for distress.</p> <p>Review of the skin assessments dated 8/28/13 indicated no new issues. Review of the skin assessment dated 9/10/13 indicated "No new issues". The assessment lacked documentation of the residents injuries. Review of the skin assessment dated 9/17/13 indicated "Bruises-areas are improving. no new issues at this time"</p> <p>Review of a nurses note dated 9/7/13 indicated, " the resident was taking antibiotic for a UTI". The nurses</p>		<p>of self-injury. The entire staff was re-educated on the proper Abuse Reporting and Prevention Policy on 10/10/2013. IDT team will review all precautions, safety measures, and follow up activity upon completion of the investigation to ensure all documentation and communication has been made. How will other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?All residents could be affected by the same alleged deficient practice. The entire staff was re-educated on the proper Abuse Reporting and Prevention Policy on 10/10/2013. Documentation of behaviors and resident Care Plans will be accessible to all staff. Following an alleged event, the administrator will immediately review the incident to ensure all requirements, communications and follow up have been completed. Once the investigation is concluded, and the final report is submitted to the ISDH, the IDT team will review the incident to ensure all follow up actions and documentation has been completed.What measures or what systemic changes will be made to ensure that the deficient practice does not reoccur? The entire staff was re-educated on the proper Abuse Reporting and Prevention Policy on 10/10/2013. Documentation of behaviors and</p>		

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	<p>notes from the dates 8/1-9/11/13 failed to document any behavior issues related to self harming behavior or aggression towards others.</p> <p>A nurses note dated 9/8/13 at 4:00 p.m., indicated skin assessment complete, message left for family members and sent fax to MD of the issue.</p> <p>Review of Social Services notes from 07/2013 through 09/12/13 lacked documentation of the incident on 9/8/13.</p> <p>Review of the physician note dated 9/10/13 indicated the visit was related to residents left eye and complaints of pain. The physician ordered resident to be sent to [Named] Hospital.</p> <p>Review of the hospital discharge summary dated 9/10/13 indicated a discharge diagnosis of left periorbital contusion.</p> <p>A nurses note dated 9/17/13 indicated, " per IDT[Interdisciplinary Team] we have come to the best of our conclusion and investigation that we feel that the cause of the facial bruise was caused from the resident rolled over and hit his face on the</p>		<p>resident Care Plans will be accessible to all staff. Following an alleged event, the administrator will immediately review the incident to ensure all requirements, communications and follow up have been completed. Once the investigation is concluded, and the final report is submitted to the ISDH, the IDT team will review the incident to ensure all follow up actions and documentation has been completed. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place? An audit form will be completed by the administrator at the inception and completion of each alleged occurrence. The administrator will be responsible for this when the event is reported, and the IDT team will complete the audit form at the finalization of the investigation.. These measures and audits will be reviewed during our monthly Continuous Quality Improvement meeting to ensure positive outcomes.</p>		

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	<p>bedside table that was next to the bed. The bedside table was moved away from the bed."</p> <p>In an interview on 9/12/13 at 10:35 a.m., Resident #K indicated, "Some young boy came in and beat the h---l out of me while I was asleep in bed. First time he has been here and I've never seen him since."</p> <p>An interview with the Social Services Director on 9/12/13 at 1:32 p.m., "If there's no notes in the chart, then I didn't chart on the incident."</p> <p>LPN#2 indicated in an interview on 9/12/13 at 2:10 p.m., the resident had told the the same story to all the staff. LPN#2 indicated the resident has no history of self harming behavior.</p> <p>The Administrator indicated in an interview on 9/12/13 at 3:10 p.m., "I did not look at this as an abusive situation, more of an injury of unknown origin because by the time staff got to me about the situation at 10:30 a.m., staff said no one entered his room. So I wait(ed) until the next day to report it and I believe staff when they said they saw no one come in his room as they visualize the hall at all times with 2 CNA's and 1 nurse. If he truly was hit 6 times like</p>			

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	<p>he says, then someone would have heard the commotion. I'm going to believe my 3 staff before someone with a BIMS(Brief Interview of Mental Status) score of 5".</p> <p>A copy of the policy titled, "Abuse Investigation" was provided by the administrator on 9/12/13 at 11:50a.m. indicated report's of "events" are promptly and thoroughly investigated.</p> <p>This Federal Tag is related to Complaint IN00136238.</p> <p>3.1-28(c) 3.1-28(d)</p>			

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F000315 SS=D	<p>483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER</p> <p>Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.</p> <p>Based on record review and interview, the facility failed to monitor a resident admitted with a urinary tract infection. This deficient practice affected 1 of 3 residents reviewed for urinary tract infections. (Resident #A)</p> <p>Findings include:</p> <p>Review of the medical record for Resident #A on 9/24/13 at 2:30p.m., indicated she was admitted to the facility on 5/31/2013. Resident #A had diagnoses including but not limited to, alzheimer's disease, anxiety, diabetes, uterine prolapse, osteoarthritis, and urinary tract infection.</p> <p>Resident #A's discharge summary from [Named] hospital indicated, "She has also been treated with Keflex [an antibiotic medication] for urinary tract</p>	F000315	<p>Preparation and/or execution of this plan of correction in general, or this corrective action in particular, does not constitute an admission of agreement by this facility of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction and specific corrective actions are prepared and/or executed in compliance with State and Federal Laws. F315- NO CATHETER, PREVENT UTI, RESTORE BLADDER** THE WATERS OF SCOTTSBURG RESPECTFULLY REQUESTS PAPER/DESK COMPLIANCE BE GRANTED FOR THIS CITATIONWhat corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?It is the policy of this facility to monitor and track the progress, or lack of progress when treating a resident UTI. In addition, it is also the policy of this facility to track and</p>	10/21/2013

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	<p>infection while here and still has 7 days left on that prescription."</p> <p>Review of the physician progress note from the facility dated 5/31/13 indicated," on Keflex x(for) 7 days."</p> <p>Review of the Medication Administration Record indicated Keflex 500 milligrams twice a day for 7 days. The medication was documented as being administered at 9 p.m. on 5/31 for the May medication record. The medication was documented as being administered at 9a.m., and 9p.m. on 6/1, 6/2, 6/3, 6/4, 6/5, 6/6, and 6/7.</p> <p>Reivew of the MDS (Minimum Data Set) dated 6/7/13 indicated urinary tract infection (UTI) as an active diagnosis within the last 30 days.</p> <p>Review of the medical record lacked documentation that Resident #A was monitored for adverse side effects while receiving an antibiotic for an UTI.</p> <p>Review of the infection control log for the months of May 2013, June 2013, August 2013, and September 2013 on 9/24/13 at 10:00a.m., lacked documentation of Resident #A's UTI.</p>		<p>monitor what anti-biotic they are being treated with, and any adverse effects as a result of treatment. Those residents that have positive UA results, will also be tracked daily, regardless of whether or not they are being actively treated with medication. Resident A no longer resides at the facility.How will other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?All residents could be affected by the same alleged deficient practice. The nursing staff and leadership team will monitor and track all residents that have a UA Panel completed in our Infection Control Log, until the Clinical Team determines the issue has resolved. All new admission and readmissions will have their transfer orders reviewed by the IDT team the day of their arrival to ensure all treatment orders are followed.What measures or what systemic changes will be made to ensure that the deficient practice does not reoccur? The nursing staff and leadership team will monitor and track all residents that have a UA Panel completed in our Infection Control Log, until the Clinical Team determines the issue has resolved. All new admission and readmissions will have their transfer orders reviewed by the IDT team the day of their arrival to ensure all</p>				

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	<p>A copy of the policy titled, "Incontinence" was provided by the Administrator on 9/17/13 at 9:33a.m. This policy indicates the intent of the facility is to ensure a resident who is content of bladder receive's appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.</p> <p>This Federal tag is related to Complaint IN00132660.</p> <p>3.1-41(2)</p>		<p>treatment orders are followed..How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place? The Infection Control Log will be reviewed and updated daily during morning meeting. Any and all changes will then be communicated to the floor staff. These measures and audits will be reviewed during our monthly Continuous Quality Improvement meeting to ensure positive outcomes.</p>		

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F000322 SS=D	<p>483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS</p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that --</p> <p>(1) A resident who has been able to eat enough alone or with assistance is not fed by naso gastric tube unless the resident ' s clinical condition demonstrates that use of a naso gastric tube was unavoidable; and</p> <p>(2) A resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills.</p> <p>Based on observation, record review, and interview, the facility failed to ensure proper care to residents receiving tube feeding's. This deficient practice affected 2 of 3 residents reviewed in an sample of 4 residents requiring tube feeding's (Resident #H and Resident #J).</p> <p>Findings include:</p> <p>1. On 9/11/13 at 10:30 a.m., Resident #H was observed to be in bed laying flat. The resident was receiving tube feeding.</p> <p>On 9/13/13 at 10:50a.m., Resident #H was observed to be in bed laying flat. His tube feeding's were complete and</p>	F000322	Preparation and/or execution of this plan of correction in general, or this corrective action in particular, does not constitute an admission of agreement by this facility of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction and specific corrective actions are prepared and/or executed in compliance with State and Federal Laws. F322 – NG TREATMENT/SERVICES- RESTORE EATING SKILLS** THE WATERS OF SCOTTBURG RESPECTFULLY REQUESTS PAPER/DESK COMPLIANCE BE GRANTED FOR THIS CITATIONWhat corrective action(s) will be accomplished for those residents found to have been affected by the deficient	10/21/2013

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	<p>he was still connected. The machine was turned off.</p> <p>On 9/15/13 at 12:10 p.m., Resident #H was observed to in bed laying flat. The resident was receiving tube feeding.</p> <p>On 9/16/13 at 4:00 p.m., the clinical record was reviewed for Resident #H. Resident #H was admitted on 6/10/13. The resident has diagnoses including but not limited to left rib fractures, stroke, hypertension, traumatic brain injury, diabetes, and sepsis. The Minimum Data Set (MDS) Assessment was reviewed for cognitive function. The MDS indicated the resident had a BIMS (Brief Interview for Mental Status) score of 6 indicating some cognitive impairment.</p> <p>The care plan was reviewed on 9/16/13 at 4:00p.m., lacked documentation of the resident refusing care related to proper position while receiving tube feedings.</p> <p>LPN#2 indicated in an interview on 9/23/13 at 6:03 p.m., resident is very non compliant. She indicated the staff provide constant reminders but he is "in his right mind."</p>		<p>practice?It is the policy of this facility to properly administer and monitor naso-gastric feeding, including, but not limited to the proper elevation of the resident's bed during tube fed administration. In addition, it is the policy of this facility to restore residents to normal eating skills, if possible. Resident H's care plan was updated to reflect the physician's order that dictated that resident H may be administered his tube feeding while lying flat, rather than at a 30-45 degree elevation. This is due to comfort, compliance, and lack of any adverse outcomes. All nurses were re-educated on the proper NG/G Tube feeding procedures. Resident J receives her tube feeding at the proper elevation, and her care plan was updated to reflect her tendency to reposition herself during her administration. Nursing staff was educated to re-position resident J if she repositioned herself to the point where her head was not at the proper elevation. How will other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?Only residents receiving NG/G Tube feedings could be affected by the same alleged deficient practice. All nurses were re-educated on the proper NG/G Tube feeding procedures. What measures or what systemic changes will be</p>		

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	<p>On 9/24/13 at 4:15 p.m., Resident #H indicated in an interview he prefers to lay flat. He indicates he will use the bed controls to lower the bed to his comfort. He also indicated he has never had any problems related to coughing or choking while receiving tube feeding.</p> <p>2. On 9/11/13 at 10:30 a.m., Resident #J was observed to be in bed receiving tube feeding. The resident's head was in the middle of the bed and was not at 30 degrees.</p> <p>On 9/13/13 at 9:30 a.m., Resident #J was observed laying in bed. The head of the bed was not at 30 degree's. The resident was receiving tube feeding's at a rate of 65 milliliters/hour.</p> <p>LPN #3 indicated on 9/13/13 at 9:35 a.m., the resident "scoots to the end of the bed, and will not stay at the head of the bed." LPN #3 indicated resident's head should be at 30 degree's.</p> <p>The clinical record was reviewed on 9/23/13 at 12:15 p.m., indicated the resident's most recent admission was 4/29/13. Resident #J had diagnosis including but not limited to hyperlipidemia, mild mental</p>		<p>made to ensure that the deficient practice does not reoccur? The Director of Nursing, or their designee, will audit/observe a minimum of 2 NG/G tube feedings per week, for 4 consecutive weeks with zero administration errors to ensure all procedures and policies are adhered to. Any negative observations will be immediately re-educated, and repeated non-compliance to policy will be documented, up to, and including termination. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place? An audit form will be completed and maintained by the Director of Nursing for each audit performed. Any errors or disciplinary action will also be maintained for each audit performed. These measures and audits will be reviewed during our monthly Continuous Quality Improvement meeting to ensure positive outcomes.</p>				

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	<p>retardation, hypertension, dysphasia, partial small bowel obstruction, and diabetes. The MDS dated 8/1/13 was reviewed. The BIMS score for the resident was 3 indicating severe cognitive impairment.</p> <p>Requested a policy on enteral nutrition from the Administrator on 9/15/13 at 12:30 p.m. He indicated the facility does not have a policy. He indicated a textbook, The Lippincott Manual of Nursing, is used as a reference and for training of staff. A copy of the section titled, " General Procedures and Treatment Modalities" was provided by the Administrator on 9/15/13 at 2:45 p.m. The Lippincott Manual of Nursing Practice, 9th edition, copyright 2010, the procedure for administration of tube feedings include the need to , "...Elevate head of bed 30 to 45 degrees..."</p> <p>This Federal tag is related to Complaint IN00131531</p> <p>3.1-44(a)(2)</p>			

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F000329 SS=D	<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 interview, the facility failed to adequately monitor residents receiving coumadin, a blood thinner. This deficient practice affected 1 of 3 residents reviewed in a sample of 5 residents receiving anticoagulant therapy (Resident #E).</p> <p>Findings include:</p> <p>1. On 9/11/13 at 12:13, the Administrator provided a list of</p>	F000329	Preparation and/or execution of this plan of correction in general, or this corrective action in particular, does not constitute an admission of agreement by this facility of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction and specific corrective actions are prepared and/or executed in compliance with State and Federal Laws. F329 – DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS** THE WATERS OF SCOTTSBURG RESPECTFULLY	10/21/2013

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	<p>residents receiving anticoagulant therapy.</p> <p>The medical record for Resident #E was reviewed on 9/17/13 at 9:30a.m. Resident was admitted to the facility on 2/28/13. Resident #E had diagnoses including but not limited to, congestive heart failure (CHF), diabetes, bipolar disorder, and morbid obesity.</p> <p>The Minimum Data Set (MDS) Assessment dated 3/7/13 indicated the resident received an anticoagulant medication.</p> <p>Review of the care plan dated 3/12/13 indicated Resident #E was at risk for hemorrhage related to use of anticoagulant med [medication] ASA[aspirin] and coumadin being used to treat A-fib [atrial fibrillation].</p> <p>Resident #E was admitted with an order to receive coumadin 8.5 milligrams by mouth daily.</p> <p>A physician order dated 3/2/13 indicated a PT/INR on 3/4/13. The lab result dated 3/4/13 indicated an INR of 1.3 seconds.</p> <p>A physician order dated 3/4/13 indicated to increase Resident #E's</p>		<p>REQUESTS PAPER/DESK COMPLIANCE BE GRANTED FOR THIS CITATIONWhat corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?It is the policy of this facility to ensure that our residents are free from unnecessary drugs, and that the medication regimen of each resident is monitored adequately. Resident E is no longer at this facility. One Coumadin draw was missed, but the 2 subsequent draws showed resident E's Coumadin levels to be within the normal range. How will other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?All residents could be affected by the same alleged deficient practice. The entire nursing staff was re-educated on the policy and procedures for anti-coagulant therapy. The IDT team reviews these orders as part of our morning meeting, and the results are tracked on a white board. What measures or what systemic changes will be made to ensure that the deficient practice does not reoccur? The entire nursing staff was re-educated on the policy and procedures for anti-coagulant therapy. The IDT team reviews these orders during morning meeting, and the results are tracked on a white board, in addition to any other abnormal</p>				

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	<p>coumadin dose to 9 mg daily and recheck the PT/INR on 3/15/13.</p> <p>The lab results dated 3/15/13 indicated an INR of 1.3 seconds. Documentation was lacking of physician notification of this lab result.</p> <p>Review of the Medication Administration Record indicated the resident received coumadin 8.5 milligrams by mouth on 3/5, 3/6, 3/7, 3/8, and 3/9/2013. Review of the Medication Administration Record indicated the resident received coumadin 9 milligrams by mouth on 3/13, 3/14, 3/15, 3/17, and 3/18/2013. The facility continued to administer coumadin 8.5 milligrams after the physician had a new order.</p> <p>Review of the Medication Administration Record indicated the resident received coumadin 10mg on 3/19, 3/21, 3/23, 3/24, 3/26, 3/28, 3/30, and 3/31/2013. Review of the medical record lacked a physician order for this medication.</p> <p>A physician order dated 3/31/13 indicated to recheck the PT/INR in the morning. The lab result dated 3/31/13 indicated an INR of 1.4 seconds.</p>		<p>medication regimens..How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place? The administrator will review this information daily in morning meeting and track the results on the common white board, and also on an audit form which has been included on the Morning Meeting Template. These measures and audits will be reviewed during our monthly Continuous Quality Improvement meeting to ensure positive outcomes.</p>				

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	<p>A physician order dated 4/1/13 indicated to give coumadin 5 milligrams now and increase daily dose to 10 milligrams daily. Recheck PT/INR in 7 days.</p> <p>No record of lab results on 4/8/13 was found in the clinical record.</p> <p>A physicians order dated 4/17/13 indicated a PT/INR was due on 4/24/13. The lab result dated 4/25/13 indicated an INR of 3.8 seconds.</p> <p>A physician order dated 4/26/13 indicated a pt/INR ordered weekly.</p> <p>The resident was discharged from the facility on 4/30/13.</p> <p>An interview with the Assistant Director of Nursing (ADON) on 9/17/13 at 11:30a.m., indicated when a resident is on coumadin, the physician determines the therapeutic range and how often the lab needs to be drawn. She indicated once the order is received, the floor nurses are responsible for ensuring the labs are drawn as ordered and the physician is notified of the results. If the physician does not adjust the dose of the coumadin, there is a standing order to draw the lab the next week. The ADON indicated the nurses use a tool</p>			

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	<p>on the medication administration record to monitor coumadin dose changes, lab results, and notification. She indicated this tool has been in use for at least 3 years. She indicated she also monitors residents receiving anticoagulant therapy with an audit tool.</p> <p>LPN #1 indicated in an interview on 9/13/13 at 11:00a.m., the nurses are responsible for ensuring the lab is drawn, logged into the clinical record, and the physician is notified. LPN#1 indicated it is the physicians discretion as to when the next lab will be drawn.</p> <p>An interview with the Director of Nursing (DON) on 9/17/13 at 12:30p.m., indicated nurses should follow the physicians order. If there is no physicians order, the lab should be drawn weekly. She indicated nurses have been using a coumadin log for each resident for the "last couple of months". The management team monitors residents on anticoagulant therapy using a white board and a binder to ensure residents are monitored.</p> <p>In an interview on 9/17/13 at 12:30p.m., reference to Resident #E's labs, the DoN indicated, "A lab</p>				

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	<p>was missed."</p> <p>Review of a document titled, "Coumadin Flow Sheet Weekly Summary" on 9/17/13 at 3:12p.m. The ADON indicated this is an "in house audit tool" she uses to monitor residents on coumadin. This document is used by the staff nurses also. Review of the audit indicated most records have start on 04/01/2013 which is not consistent with records on the medication administration record. Review of Resident E's record lacked a coumadin log that the DoN and ADON indicated was used to monitor coumadin.</p> <p>A policy titled, " Coumadin Guidelines" was provided by the Administrator on 9/12/13 at 11:50a.m. The policy indicated, ...After the initial INR[laboratory test], follow-up INR's may be done every three to five days. INR's are then continued every three to five days until two consecutive stable therapeutic INR readings are established, usually a level between 2 and 3.5. After the two consecutive INR reading's are obtained that are between 2 and 3.5, unidentified support INR's to be drawn weekly for four weeks. When a resident is stable after weekly INRs, then an INR</p>			

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	<p>will be performed every four weeks as long as warfarin is being used....</p> <p>3.1-48(a)1 3.1-48(a)2 3.1-48(a)3</p>				