

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155137	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/09/2013
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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVING CENTER-VALPARAISO	STREET ADDRESS, CITY, STATE, ZIP CODE 251 STURDY RD VALPARAISO, IN 46383
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F000000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey date(s): December 3, 4, 5, 6 and 9, 2013</p> <p>Facility number: 000062 Provider number: 155137 AIM number: 100271400</p> <p>Survey team: Jennifer Redlin, RN, TC Caitlyn Doyle, RN Regina Sanders, RN (12/3, 12/4, 12/5, 12/6, 2013) Heather Hite, RN (12/4, 12/5, 12/6, 12/9, 2013)</p> <p>Census bed type: SNF/NF: 82 Total: 82</p> <p>Census Payor type: Medicare: 9 Medicaid: 67 Other: 6 Total: 82</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed on</p>	F000000	Preparation, submission and implementation of this plan of correction does not constitute an admission of or agreement with the facts and conclusions set forth on this survey report. Our Plan of Correction is prepared and executed as a means to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements.	
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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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	December 12, 2013, by Janelyn Kulik, RN.			

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F000246 SS=B	<p>483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. Based on record review and interview, the facility failed to ensure the resident individual preferences were followed, related to not giving the resident a choice of the amount of bathing he would prefer, for 1 of 3 residents reviewed for choices. (Resident #90)</p> <p>Findings include:</p> <p>During an interview on 12/03/13 at 10:48 a.m., Resident #90 indicated he had not been given a choice for the amount of showers he would like to receive. He indicated the facility told him he was scheduled for two a week.</p> <p>Resident #90's record was reviewed on 12/04/13 at 2:43 p.m. The resident's diagnoses included, but were not limited to, hypertension and diabetes.</p> <p>The Admission MDS (Minimum Data Set) Assessment, dated 07/07/13,</p>	F000246	<p>1) Resident number 90 was interviewed regarding his preferences for his daily routine concerning showers. 2) All residents were interviewed regarding preferences for daily routines concerning showers. A whole house audit was conducted, and the shower schedule was updated accordingly. 3) Residents will be interviewed upon admission and quarterly thereafter regarding shower schedules. Preference worksheets and shower schedules will be updated accordingly. 4) Social services and the Alzheimer's Director will maintain preference worksheets and will update the shower schedule accordingly. Preferences will be reviewed in morning meeting for any resident who was admitted or had a quarterly assessment since the last morning meeting. All admissions will have preferences reviewed by either Social Services or the Alzheimer's Director within 72 hours. All residents will be offered a shower within 72 hours. Preferences and timeliness will be reviewed during</p>	01/08/2014			

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	<p>indicated the resident's cognition was intact, required extensive assistance with bathing, and it was somewhat important to him to choose what clothes to wear and choose his type of bathing.</p> <p>The, "South Shower Schedule", received from the Director of Clinical Education (DCU) as current indicated the resident was scheduled for a shower on Tuesday and Friday evenings.</p> <p>During an interview on 12/04/13 at 2:07 p.m., the Director of Nursing (DoN) indicated the Lead CNA's schedule the resident showers when the residents were admitted.</p> <p>During an interview on 12/04/13 at 2:07 p.m., CNA #1 (evening Lead CNA) indicated when the resident is admitted they are given a shower within the first 24 hours and if the resident comes in on day shift they are put on the day shift schedule and if they come in on evening shift, they are put on the evening shift shower schedule. The shower list is done by room number. The rooms have set days already, if the resident wants it another time we will accommodate them. She indicated the Nurse who does the admission will ask the</p>		the facility's monthly QAPI meeting for 6 months. 5) January 8, 2014		

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	<p>resident what they prefer for bathing.</p> <p>During an interview on 12/04/13 at 2:13 p.m., LPN #2 indicated she would ask the resident when they want a shower. She indicated they informed the resident of the shower days they are scheduled for, then ask if they have other preferences.</p> <p>During an interview on 12/04/13 at 2:33 p.m., Resident #90 indicated the facility had informed him he would get a shower two times a week. He indicated no one had ever asked him if he wanted more or less showers, or gave him the choice to change the amount of showers he received. He indicated the two showers a week was alright for now, and again voiced no one had asked him how many showers he would like.</p> <p>During an interview on 12/04/13 at 3:12 p.m., the Admissions Coordinator indicated the resident and/or family are informed the facility would provide a shower to the resident two times a week and if they would like more they were to let the staff know. She indicated she did not ask the resident and/or family what they would like.</p> <p>During an interview on 12/05/13 at</p>				

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	<p>11:29 a.m., the South Unit Social Service Director indicated a new form had just been implemented to ask the residents how often they wanted a shower. She indicated she had just asked Resident #90 how many showers he preferred. She indicated when Resident #90 was asked how many showers he preferred, he requested a shower four times a week.</p> <p>3.1-3(v)(1)</p>			

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F000282 SS=D	<p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>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 interview, the facility failed to ensure residents' care plans and physician's orders were followed, related to a medication and daily weights for 2 of 23 residents reviewed for care plans and physician's orders. (Residents #41 and #90)</p> <p>Findings include:</p> <p>1. During a record review on 12/03/13 at 1:20 p.m., Resident #90's Medication Administration Record (MAR), dated 11/13, indicated the resident received Coumadin (blood thinner) 7.5 mg (milligrams) every evening from 11/01/13 through 11/30/13 and an additional Coumadin 7.5 mg (equal 15 mg) in the evening on November 2, 3, 5, 7, 9, 10, 12, 14, 16, 17, 19, 21, and 23, 2013.</p> <p>Resident #90's record was reviewed on 12/04/13 at 2:43 p.m. The resident's diagnoses included, but were not limited to, history of deep vein thrombosis (DVT) (blood clot), cardiac murmurs, and hypertension.</p>	F000282	<p>1) Resident number 41's weight orders were reviewed and corrected by the physician.</p> <p>Resident number 90's Coumadin order was reviewed by the DNS and ADNS and the order had already been corrected on 11/24/13. The physician was then notified of the medication errors prior to 11/24/13. Physician ordered a PT/INR for three days and changes were made accordingly per physician's orders. 2) All those who are on Coumadin therapy that could be potentially affected had their charts reviewed and no further action was needed. All resident's weight orders were reviewed and corrective action was taken as needed. 3) Weight and Coumadin orders will be reviewed daily for changes during Clinical Startup, and documented on Clinical Startup Worksheets. Director of Clinical Education will perform in-services with licensed nursing staff concerning anticoagulant therapy, following care plans, and following physician orders. 4) Coumadin audits will be performed by the ADNS/Designee 5 times a week for 4 weeks, then weekly thereafter for 6 months. The</p>	01/08/2014			

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	<p>A care plan, dated 07/12/13, indicated the resident had an impaired cardiovascular status related to hypertension and a history of DVT. The approaches included, medications as ordered by the physician.</p> <p>A Physician's order, dated 10/23/13, indicated orders for Coumadin 7.5 mg, one time a day every Sunday, Tuesday, Thursday, and Saturday and 5 mg of Coumadin daily on Monday, Wednesday, and Friday.</p> <p>A Physician's order, dated 10/30/13, indicated to change the Coumadin dosages to 7.5 mg to every evening.</p> <p>The MAR, dated 10/13, indicated the Coumadin 5 mg on Monday, Wednesday and Friday had been discontinued on 10/30/13, and the Coumadin 7.5 mg every Sunday, Tuesday, Thursday, and Saturday was left on the MAR and the order for Coumadin 7.5 mg daily was also added to the MAR.</p> <p>The MAR, dated 11/13, indicated the Coumadin 7.5 mg every evening continued from 11/01/13 through 11/30/13 and the additional Coumadin 7.5 mg every Sunday,</p>		<p>DNS/Designee, in the morning Clinical Startup meeting, will review new weight orders for accuracy.. Weights and Coumadin audit sheets will be reviewed monthly in the facility's QAPI meeting for 6 months.5) January 8, 2014</p>				

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	<p>Tuesday, Thursday, and Saturday, also continued to indicate the resident received 15 mg of Coumadin on November 2, 3, 5, 7, 9, 10, 12, 14, 16, 17, 19, 21, and 23, 2013.</p> <p>The 11/13 MAR indicated the Coumadin 7.5 mg on Sunday, Tuesday, Thursday, and Saturday had been discontinued on 11/23/13.</p> <p>The Nurses' Progress Notes, dated 10/31/13 at 4:09 p.m., 11/3/13 at 4:46 p.m., 11/5/13 at 6:13 p.m., 11/12/13 at 4:57 p.m., 11/16/13 at 4:48 p.m., 11/17/13 at 4:31 p.m., and 11/19/13 at 4:18 p.m., indicated the second dose of Coumadin 7.5 mg had not been given because it was a duplicate order.</p> <p>During an interview on 12/04/13 at 8:19 a.m., the Director of Nursing indicated when the Nurse received the change in the Coumadin order, she should have also discontinued Coumadin 7.5 mg on Sunday, Tuesday, Thursday, and Saturday when she discontinued the 5 mg of Coumadin.</p> <p>During an interview on 12/05/13 at 10 a.m. with the Director of Nursing (DoN) also present, the Director of Clinical Education (DCE) indicated he</p>			

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	<p>had audited the dispensing record and on November 2, 7, 9, 10, 14, 21, and 23, 2013, the resident had received 12.5 mg of Coumadin. He indicated the pharmacy had dispensed two 5 mg tablets of Coumadin and one 2.5 tablet of Coumadin (total of 12.5). He indicated the MAR indicated the resident had received two doses of Coumadin 7.5 mg (total of 15 mg) on those days.</p> <p>A facility policy, dated 5/12, titled, "Oral Medication Administration", received as current from the DCE, indicated, "...Review and confirm medication orders for each individual resident on the Medication Administration Record PRIOR to administering medications to each resident..."</p> <p>2. Resident #41's record was reviewed 12/05/13 at 11:34 a.m. The resident was admitted into the facility on 10/19/13. The resident's diagnoses included, but were not limited to, end stage renal disease with dialysis, dementia, and malnutrition due to the chronic renal disease.</p> <p>A care plan, dated 11/01/13, indicated the resident was at risk for inadequate oral intakes at meals.</p>						

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	<p>The interventions included, weigh and record.</p> <p>A Physician's Order, dated 10/19/13, indicated an order for daily weights.</p> <p>The weight record indicated the resident's weights were obtained on October 20 and 28, 2013, November 5, 9, and 25, 2013, and December 2, 2013.</p> <p>During an interview on 12/05/13 at 2:12 p.m. the DCE indicated the resident had not been weighed daily.</p> <p>3.1-35(g)(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 ensure residents were free from unnecessary medications, related to incorrect dosages of a blood thinner and not monitoring a blood level, which could be effected by a medication, as recommended by the Pharmacist and ordered by the Physician, for 2 of 6 residents reviewed for unnecessary medications. (Residents #58 and #90)</p> <p>Findings include:</p>	F000329	1) Resident number 90's Coumadin order was reviewed by the DNS and ADNS and the order had already been corrected on 11/24/13. The physician was then notified of the medication errors prior to 11/24/13.. Physician ordered a PT/INR for three days and changes were made accordingly per physician's orders. Resident number 58's lab orders were reviewed. The physician was notified of the missed lab and a new order was written for HbA1C to be drawn on 12/6/13. The lab was drawn and	01/08/2014			

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	<p>1. During a record review on 12/03/13 at 1:20 p.m., Resident #90's Medication Administration Record (MAR), dated 11/13, indicated the resident received Coumadin (blood thinner) 7.5 mg (milligrams) every evening from 11/01/13 through 11/30/13 and an additional Coumadin 7.5 mg (equal 15 mg) in the evening on November 2, 3, 5, 7, 9, 10, 12, 14, 16, 17, 19, 21, and 23, 2013.</p> <p>Resident #90's record was reviewed on 12/04/13 at 2:43 p.m. The resident's diagnoses included, but were not limited to, history of deep vein thrombosis (DVT) (blood clot), cardiac murmurs, and hypertension.</p> <p>A care plan, dated 07/12/13, indicated the resident had an impaired cardiovascular status related to hypertension and a history of DVT. The approaches included, medications as ordered by the physician.</p> <p>A Physician's order, dated 10/23/13, indicated an order for Coumadin (blood thinner) 7.5 mg one time a day every Sunday, Tuesday, Thursday, and Saturday and 5 mg of Coumadin daily on Monday, Wednesday, and Friday.</p>		<p>the results were reviewed by the physician with no further orders noted. 2) All those who are on Coumadin therapy that could be potentially affected had their charts reviewed and no further action was needed. All resident labs from 11/1/13 to 12/6/13 reviewed and no further discrepancies were found. 3) Coumadin and lab orders will be reviewed daily for changes during Clinical Startup. and documented on the Clinical Startup Worksheets. Director of Clinical Education will perform in-services with Licensed nursing staff concerning anticoagulant therapy, following care plans, and following physician orders. 4) Coumadin and lab audit sheets will be completed by the ADNS/Designee 5 times a week for 4 weeks, then weekly for 8 weeks, then monthly for 12 weeks. Coumadin and lab audits will be reviewed in the facility's monthly QAPI meeting for 6 months.5) January 8, 2014</p>				

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	<p>A Physician's order, dated 10/30/13, indicated to change the Coumadin dosages to 7.5 mg to every evening.</p> <p>The MAR, dated 10/13, indicated the Coumadin 5 mg on Monday, Wednesday and Friday had been discontinued on 10/30/13, and the Coumadin 7.5 mg every Sunday, Tuesday, Thursday, and Saturday had been left on the MAR, and the order for Coumadin 7.5 mg daily was also added to the MAR.</p> <p>The MAR, dated 11/13, indicated the Coumadin 7.5 mg every evening continued from 11/01/13 through 11/30/13 and the additional Coumadin 7.5 mg every Sunday, Tuesday, Thursday, and Saturday also continued, to indicate the resident received 15 mg of Coumadin on November 2, 3, 5, 7, 9, 10, 12, 14, 16, 17, 19, 21, and 23, 2013.</p> <p>The 11/13 MAR indicated the Coumadin 7.5 mg on Sunday, Tuesday, Thursday, and Saturday had been discontinued on 11/23/13.</p> <p>The Nurses' Progress Notes, dated 10/31/13 at 4:09 p.m., 11/3/13 at 4:46 p.m., 11/5/13 at 6:13 p.m., 11/12/13 at 4:57 p.m., 11/16/13 at 4:48 p.m.,</p>			

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	<p>11/17/13 at 4:31 p.m., and 11/19/13 at 4:18 p.m., indicated the second dose of Coumadin 7.5 mg had not been given because it was a duplicate order.</p> <p>During an interview on 12/04/13 at 8:19 a.m., the Director of Nursing indicated when the Nurse received the change in the Coumadin order, she should have also discontinued Coumadin 7.5 mg on Sunday, Tuesday, Thursday, and Saturday.</p> <p>During an interview on 12/05/13 at 10 a.m. with the Director of Nursing (DoN) also present, the Director of Clinical Education (DCE) indicated he had audited the dispensing record and on November 2, 7, 9, 10, 14, 21, and 23, 2013, the resident had received 12.5 mg of Coumadin. He indicated the pharmacy had dispensed two 5 mg tablets of Coumadin and one 2.5 tablet of Coumadin (total of 12.5). He indicated the MAR indicated the resident had received two doses of Coumadin 7.5 mg (total of 15 mg) on those days. He indicated there was no indication the extra 5 mg tablet of Coumadin had been returned to the Pharmacy or had been destroyed in the facility.</p>			

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	<p>A facility policy, dated 05/12, titled, "Administration Procedures for All Medications", received as current from the DCE, indicated, "...Check the label against the order on the MAR..."</p> <p>A facility policy, dated 5/12, titled, "Oral Medication Administration", received as current from the DCE, indicated, "...Review and confirm medication orders for each individual resident on the Medication Administration Record PRIOR to administering medications to each resident..."</p> <p>2. Resident #58's record was reviewed on 12/4/13 at 1:51 p.m. The resident's diagnoses included, but were not limited to, anemia, heart failure, hypertension, aphasia, dementia, seizure disorder, anxiety, bipolar, and asthma.</p> <p>Review of a pharmacy recommendation dated 10/23/13, indicated the resident was currently taking Abilify (antipsychotic medication) and recommended to consider ordering an HgbA1C (blood glucose test) now and then annually thereafter.</p>			

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	<p>A Physicians Order dated 10/24/13, indicated HgbA1c on 10/25/13 then annually thereafter.</p> <p>Review of the lab requisition form dated 10/25/13 indicated the resident was to have an HgbA1c completed on 10/25/13. There was a lack of documentation in the record to indicate the HgbA1c had been completed.</p> <p>The resident had a glucose monitoring test on 10/21/13 and it was 116 in a reference range of 70-110. Glucose monitoring test on 10/29/13 indicated a result of 152.</p> <p>The HgbA1c was completed on 12/6/13 and the result was 6.5 in a reference range of 4.4-6.0.</p> <p>Interview with Licensed Practical Nurse (LPN) #3 on 12/5/13 at 2:45 p.m., indicated the lab was ordered on the lab requisition form but she could not find a fax confirmation the order was sent to the lab. She further indicated she called the lab and the blood test had not been completed.</p> <p>Interview with the Director of Nursing (DoN) on 12/5/13 at 4:15 p.m., indicated the blood test was ordered on the lab requisition form but was</p>			

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	not faxed to the lab so the blood test was not completed as ordered. 3.1-48(a)(6)			

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F000428 SS=D	<p>483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON</p> <p>The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.</p> <p>The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.</p> <p>Based on record review and interview, the facility failed to ensure medication irregularities were found and reported to the attending Physician, and the Director of Nursing (DoN), related to the incorrect dosage of Coumadin (blood thinner) being dispensed and administered for 1 of 6 residents reviewed for unnecessary medications. (Resident #90)</p> <p>Findings include:</p> <p>During a record review on 12/03/13 at 1:20 p.m., Resident #90's Medication Administration Record (MAR), dated 11/13, indicated the resident received Coumadin (blood thinner) 7.5 mg (milligrams) every evening from 11/01/13 through 11/30/13 and an additional Coumadin 7.5 mg (equal 15 mg) in the evening on November 2, 3, 5, 7, 9, 10, 12, 14, 16, 17, 19, 21, and 23, 2013.</p> <p>Resident #90's record was reviewed</p>	F000428	<p>1) Resident number 90's chart was reviewed by the Pharmacist and the DNS for accuracy. 2) The Pharmacist reviewed, and will continue monthly reviews, of all residents' charts for the appropriateness and accuracy of all medications. 3) Medication administration in-service will be completed by Director of Clinical Education (DCE) with licensed nursing staff. 4) Pharmacy recommendations will be forwarded to Medical Director. The DNS/designee will also follow-up on the pharmacy recommendation. Upon MD review they will be noted in the resident's chart. Pharmacy recommendation summary will be reviewed in the facility's monthly QAPI meeting..5) January 8, 2014 We respectfully request a desk review.</p>	01/08/2014			

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	<p>on 12/04/13 at 2:43 p.m. The resident's diagnoses included, but were not limited to, history of deep vein thrombosis (DVT) (blood clot), cardiac mummurs, and hypertension.</p> <p>A Physician's order, dated 10/23/13, indicated an order for Coumadin 7.5 mg one time a day, every Sunday, Tuesday, Thursday, and Saturday and 5 mg of Coumadin daily on Monday, Wednesday, and Friday.</p> <p>A Physician's order, dated 10/30/13, indicated to change the Coumadin dosages to 7.5 mg to every evening.</p> <p>The MAR, dated 10/13, indicated the Coumadin 5 mg on Monday, Wednesday and Friday had been discontinued on 10/30/13, and the Coumadin 7.5 mg every Sunday, Tuesday, Thursday, and Saturday remained on the MAR. The order for Coumadin 7.5 mg daily was also added to the MAR.</p> <p>The MAR, dated 11/13, indicated the Coumadin 7.5 mg every evening continued from 11/01/13 through 11/30/13 and the additional Coumadin 7.5 mg every Sunday, Tuesday, Thursday, and Saturday also continued, to indicate the resident received 15 mg of Coumadin</p>				

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	<p>on November 2, 3, 5, 7, 9, 10, 12, 14, 16, 17, 19, 21, and 23, 2013.</p> <p>The 11/13 MAR indicated the Coumadin 7.5 mg on Sunday, Tuesday, Thursday, and Saturday had been discontinued on 11/23/13.</p> <p>The Nurses' Progress Notes, dated 10/31/13 at 4:09 p.m., 11/3/13 at 4:46 p.m., 11/5/13 at 6:13 p.m., 11/12/13 at 4:57 p.m., 11/16/13 at 4:48 p.m., 11/17/13 at 4:31 p.m., and 11/19/13 at 4:18 p.m., indicated the second dose of Coumadin 7.5 mg had not been given because it was a duplicate order.</p> <p>During an interview on 12/04/13 at 8:19 a.m., the Director of Nursing indicated when the Nurse received the change in the Coumadin order, she should have also discontinued Coumadin 7.5 mg on Sunday, Tuesday, Thursday, and Saturday. She indicated once the order was written, the Nurse would send the order to the Pharmacy and the Pharmacy would change the dosage in the medication dispensing machine. She indicated the facility had a medication dispensing machine in the South Medication room and the medications were dispensed for each resident each night and the Midnight</p>						

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	<p>Nurse would place the medications in the Medication Cart each night.</p> <p>During an interview on 12/05/13 at 10 a.m. with the Director of Nursing (DoN) also present, the Director of Clinical Education (DCE) indicated he had audited the dispensing record and on November 2, 7, 9, 10, 14, 21, and 23, 2013, the resident had received 12.5 mg of Coumadin. He indicated the machine had dispensed two 5 mg tablets of Coumadin and one 2.5 tablet of Coumadin (total of 12.5) and the MAR indicated the resident had received two doses of Coumadin 7.5 mg (total of 15 mg) on those days. The DoN indicated it can take the Pharmacy up to 48 hours to change the orders in the medication dispensing machine once they received the order. She indicated she was unsure why the Pharmacy continued to dispense the extra Coumadin 5 mg tablet.</p> <p>A Pharmacy Plan of Correction, received from the Pharmacy Consultant on 12/05/13 at 8:41 a.m., indicated the Pharmacy had begun educating the staff on the policy and procedure for orders and discontinuation verification and discontinuing orders. The Pharmacy Consultant provided no further</p>			

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	<p>information in regards to why the extra Coumadin 5 mg tablet was dispensed.</p> <p>The Medication Regimen Review Summary, dated 11/11/13, indicated the Pharmacist reviewed the resident's medication orders and the recommendation orders were to consider discontinuing the as needed ibuprofen due to increased risk of gastro-intestinal bleeding due to aspirin and Coumadin usage and to discontinue the resident's Prilosec and to start Zantac 150 mg twice a day for 14 days then 150 mg daily for seven days and then discontinue. The review lacked documentation the resident had been receiving the incorrect dosage of Coumadin.</p> <p>3.1-25(i)</p>				