

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155441	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/20/2011
NAME OF PROVIDER OR SUPPLIER CORYDON NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 315 COUNTRY CLUB RD CORYDON, IN47112		
(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	
F0000	<p>This visit was for Investigation of Complaint IN00100950.</p> <p>Complaint IN00100950 - Substantiated. Federal/state deficiencies related to the allegations are cited at F157, F282, F309, F333, F387, F502, and F514.</p> <p>Survey date: 12/19/11 and 12/20/11</p> <p>Facility number: 000338 Provider number: 155441 AIM number: 100287590</p> <p>Survey team: Jennie Bartelt, RN, TC Gloria Reisert, MSW</p> <p>Census bed type: SNF/NF: 29 Total: 29</p> <p>Census payor type: Medicare: 3 Medicaid: 26 Other: 0 Total: 29</p> <p>Sample: 5</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p>	F0000			

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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/12/2012

FORM APPROVED

OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155441	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/20/2011
NAME OF PROVIDER OR SUPPLIER CORYDON NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 315 COUNTRY CLUB RD CORYDON, IN47112		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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	
	Quality review completed 12/22/11 Cathy Emswiller RN				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155441	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/20/2011
NAME OF PROVIDER OR SUPPLIER CORYDON NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 315 COUNTRY CLUB RD CORYDON, IN47112		
(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	
F0157 SS=D	<p>A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>Based on record review and interview, the facility failed to ensure the physician and family were notified timely of a resident's fall. The facility also failed to notify the physician for clarification of physician's orders related to management of the resident's diuretic medications. The facility also failed to notify the physician</p>	F0157	<p>Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth on the statement of deficiencies. This plan of correction is prepared and/or executed solely because</p>	01/19/2012	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155441	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/20/2011
NAME OF PROVIDER OR SUPPLIER CORYDON NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 315 COUNTRY CLUB RD CORYDON, IN47112		
(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	
	<p>timely of a critical lab value. The deficient practice affected 1 of 5 residents reviewed related to physician notification in a sample of 5. (Resident D)</p> <p>Findings include:</p> <p>The clinical record for Resident D was reviewed on 12/19/11 at 12:00 noon.</p> <p>A. The Nursing Admission Data Review indicated the date of readmission from the hospital was 6/8/11 at 8:45 p.m.</p> <p>Nurse's Notes on 6/8/11 at 9:48 p.m., indicated, "POA [Power of Attorney] [name of POA] returned call. She was informed of resident arrival...I informed POA that resident was weak & unable to stand or transfer to BSC [bedside commode]....I informed her that we would use a bed pan for voiding tonight and that tomorrow PT [physical therapy] would access [sic] her. POA was satisfied, thanked me and hung up."</p> <p>The next Nurse's Note, on 6/9/11 at 1:40 a.m., indicated the resident complained of pain in the left knee, and a "bruise approx [approximately] 7 in [inches] log is visible. Resident C/O [complained of] pain whenever leg is touched or moved. Resident said injury happened during assisted fall to the floor while transferring</p>		<p>required. F 157 Notification of Change (a) What corrective action(s) will be accomplished for those residents found to have been affected by the practice: ISSUE A: This information was received from closed record review. This was a post event that happened >6 months ago – this was again reviewed with the staff identified (LPN #5 and CNA # 16) appropriate educational/disciplinary action was taken. CNA # 8 is no longer employed by this facility. ISSUE B: This issue was addressed on 12/7/11 when the K+ results of 6.3 were identified. Licensed staff on duty during this event is no longer employed in this facility. ISSUE # C: The licensed nurse responsible for MD notification and the documentation received appropriate disciplinary action and education of MD notification on critical labs. (b) How you will identify other residents having potential to be affected by the same practice and what corrective action will be taken:</p> <ul style="list-style-type: none"> · Event records for the last 6 months were reviewed to identify any "falls" to assure that MD/Responsible Party had been notified in a timely manner. · A med review to identify any resident on a diuretic – to determine if it is or is not a K+ depleting diuretic and that the MD is fully aware of the current drug 		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155441	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/20/2011
NAME OF PROVIDER OR SUPPLIER CORYDON NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 315 COUNTRY CLUB RD CORYDON, IN47112		
(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	
	<p>from BSC [bedside commode] to bed....MD notified...." Nurse's Notes indicated the physician ordered an x-ray of the left knee, and a subsequent note indicated the resident had no fracture. The Nurse's Note failed to indicate the Power of Attorney was notified of the resident's fall and physician's order for x-ray.</p> <p>A Nurse's Note on 6/9/11 at 12:00 noon indicated, "Left msg [message] [symbol for with] POA r/t [related to] residents x-ray results from this morning's x-ray. Message included information regarding lack of resident's c/o discomfort."</p> <p>During confidential interview on 12/18/11, a family member of Resident D indicated the family was notified the resident had no fracture, but the family had been unaware the resident had fallen and needed an x-ray.</p> <p>A late-entry Nurse's Note, dated 6/15/11 at 1:45 p.m., indicated, "On 6/8/11 at approx 2100 [9:00 p.m.], resident was transferring to bed via walker and assist X 3 (This nurse [LPN #5], [name of CNA #16], CNA, and [name of CNA #8], CNA) when resident became anxious and yelled out, 'My foot is giving out.' [Name of CNA #16] and this nurse reassured resident, but resident insisted standing was not possible. This nurse positioned</p>		<p>regimen · Lab review has been completed on current residents for the last 3 months to ensure all critical labs have been reported to the MD and responsible party notified. (c) What measures will be put into place or what systematic changes you will make to ensure that the practice does not recur: Licensed staff were re-educated regarding timely notification/ documentation of physician and responsible party regarding any fall event. Pharmacy contacted to educate licensed staff on the different forms of diuretics and its effect on electrolytes. Current license staff have been re-educated on the responsibility of MD notification regarding critical lab levels. (d) How the corrective action(s) will be monitored to ensure the practice will not recur, i.e., what quality assurance program will be put into place: The monitoring of this tag will be the joint responsibility of the DNS/MDS/designee as they review: ·Fall events – during standup meeting for timely MD/Responsible party notification. This will be on-going. ·Weekly review (for the next 4 weeks then bi-weekly X 2 months) of resident(s) currently on diuretic – checking type, changes and current K+ replacement if applicable.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155441	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/20/2011
NAME OF PROVIDER OR SUPPLIER CORYDON NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 315 COUNTRY CLUB RD CORYDON, IN47112		
(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	
	<p>W/C [wheel chair] behind resident. [Name of CNA #16], CNA, and this nurse advised resident to allow us to get her in W/C. Resident then stated, 'I'm going down.' This nurse and [Name of CNA #16] assured resident of her being held and prevented from incident. Resident then let go of walker. [Name of CNA #16], CNA, [Name of CNA #8], CNA, and this nurse lowered resident to floor. Resident denied pain, just stated she was nervous. Resident was visibly anxious, but upon assessment no S/S [signs and symptoms] of injury was [sic] noted." Documentation failed to indicate the physician or family was notified of the fall.</p> <p>An Event Analysis related to the fall on 6/8/11 was provided by the Administrator on 12/20/11 at 11:30 a.m. The Event Analysis indicated the fall occurred when the resident requested to use the bedside commode "upon return from the hospital." The Event Analysis indicated the physician was notified of the resident's fall on 6/9/11 at 12:15 a.m.</p> <p>During interview on 12/20/11 at 1:00 p.m., the Administrator reviewed the Nurse's Notes and Event Analysis and indicated the nurse did not document the resident's fall at the time of the fall. The Administrator indicated the nurse did not</p>		<p>·Weekly lab reviews (for the next 4 weeks then bi-weekly X 2 months) of residents lab orders/results and MD notification if the lab is a critical level. The report of these findings will be presented at the Risk Management/QA Committee meeting to determine if compliance has been achieved and quarterly monitoring my the RDCO when completing their QSR which included these categories, (e) Date of compliance: 1/19/2012</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155441	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/20/2011
NAME OF PROVIDER OR SUPPLIER CORYDON NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 315 COUNTRY CLUB RD CORYDON, IN47112		
(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	
	<p>notify the physician of the fall at the time of the fall and should have.</p> <p>B. Physician's orders, dated 11/28/11, included, but were not limited to, "Spirolactone [diuretic that does not deplete potassium] 25 mg, give one tablet by mouth daily" and "D/C [discontinue] Bumex [diuretic that depletes potassium]." Physician's recapitulation orders for November 2011 included, but were not limited to, "Potassium Cl [chloride] ER [extended release] 10 meq [milliequivalents] capsule, give 4 caps (40 meq) orally 3 times a day hypokalemia [low blood potassium]**Note dosage/strength**."</p> <p>Documentation failed to indicate the physician was notified in regard to the potential need for change in treatment related to the resident's potassium dosing when the diuretic was changed from Bumex to Spirolactone.</p> <p>During interview on 12/20/11 at 1:15 p.m., the Director of Nursing Services (DNS) indicated she could find no documentation to indicate the physician was contacted related to the resident's potassium dosing when the Bumex was discontinued.</p> <p>C. A lab report for a BMP (Basic</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155441	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/20/2011
NAME OF PROVIDER OR SUPPLIER CORYDON NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 315 COUNTRY CLUB RD CORYDON, IN47112		
(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	
	<p>Metabolic Profile) indicated the final report to the facility was on 12/7/11 at 3:00 a.m. Results of the blood work included, but were not limited to, "Potassium 6.3 RCH [repeat critical high]" with the normal range of 3.5 to 5.3 meq/L [liter]</p> <p>Nurse's Notes on 12/7/11 at 3:10 a.m., indicated, "BMP results faxed to MD. [Symbol for no] critical's...."</p> <p>During interview on 12/20/11 at 11:30 a.m., the Administrator indicated the nurse did not call the physician to report the critical high potassium level. The Administrator indicated if the nurse could not reach the resident's physician, she should call the on-call physician, and if she could not reach the on-call physician, she should call the Director of Nursing Services or the Administrator.</p> <p>This federal tag relates to Complaint IN00100950.</p> <p>3.1-5(a)(2) 3.1-5(a)(3)</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155441	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/20/2011
--	---	--	---

NAME OF PROVIDER OR SUPPLIER CORYDON NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 315 COUNTRY CLUB RD CORYDON, IN47112
---	--

(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
F0282 SS=D	<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 medications were administered and blood tests were obtained as ordered by the physician for 1 of 5 residents reviewed related to physician's orders in a sample of 5. (Resident D)</p> <p>Findings include:</p> <p>The clinical record for Resident D was reviewed on 12/19/11 at 12:00 noon.</p> <p>A. Physician's orders, dated 11/28/11, included, but were not limited to, "BMP [Basic Metabolic Profile] on 12/5/11."</p> <p>Documentation failed to indicate the BMP was obtained on 12/5/11.</p> <p>During interview on 12/20/11 at 1:15 p.m., the Director of Nursing Services (DNS) indicated the physician's order for the lab test was transcribed incorrectly</p>	F0282	<p>Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth on the statement of deficiencies. This plan of correction is prepared and/or executed solely because required. F 282 Services by Qualified Staff (a) What corrective action(s) will be accomplished for those residents found to have been affected by the practice: This information was obtained from a close record review. ISSUE A: Licensed nurse who was identified responsible for transcribing the order correctly but boxing in the wrong day on the TAR has been appropriately disciplined and re-educated on the responsibility of accuracy when transcribing orders to the TAR. ISSUE B: Licensed nurse who was identified responsible for this has been re-educated on the responsibility regarding obtaining</p>	01/19/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155441	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/20/2011
NAME OF PROVIDER OR SUPPLIER CORYDON NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 315 COUNTRY CLUB RD CORYDON, IN47112		
(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	
	<p>onto the Treatment Administration Record, and the test was not obtained as ordered on 12/5/11. The DNS indicated the nurse who transcribed the order had received education related to the transcription error.</p> <p>B. Physician's recapitulation orders for November 2011 included, but were not limited to, "Metolazone 2.5 mg tablet, give 1 tablet orally every Monday, Wednesday and Friday for CHF [congestive heart failure]**Note frequency**."</p> <p>Documentation failed to indicate the physician's order was discontinued.</p> <p>The Medication Administration Record (MAR) for November 2011 indicated the resident received the Metolazone 2.5 mg as ordered through 11/28/11. A notation on the MAR indicated, "D/C [discontinue] 11/28." The dose scheduled on the MAR for 11/30/11 was not administered.</p> <p>Printed physician's recapitulation orders for December 2011 included, but were not limited to, "Metolazone 2.5 mg tablet, give 1 tablet orally every Monday, Wednesday and Friday for CHF [congestive heart failure]**Note frequency**." Handwritten next to the</p>		<p>written orders for changes in medication regimen and appropriately disciplined. (b) How you will identify other residents having potential to be affected by the same practice and what corrective action will be taken: Review of current active residents Chart MAR/TAR reconciliation has been completed to ensure that order transcriptions are accurate when place on the TAR and that there are no med discontinuation without a supporting physician order. (c) What measures will be put into place or what systematic changes you will make to ensure that the practice does not recur: License staff have been re-educated on: · the responsibility of accuracy when transcribing physician orders to the TAR. · the responsibility regarding obtaining written orders for changes in medication regimen before any discontinuation of a med/treatment. (d) How the corrective action(s) will be monitored to ensure the practice will not recur, i.e., what quality assurance program will be put into place: The facility DNS/designee will conduct a random weekly audit of at least 5 residents per week x 4 weeks and every 2 weeks for the next 2 months - to ensure that each resident's plan of care is</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155441	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/20/2011
NAME OF PROVIDER OR SUPPLIER CORYDON NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 315 COUNTRY CLUB RD CORYDON, IN47112		
(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	
	<p>entry was "D/C 11/28/11." The December 2011 physician's orders were signed by the physician and dated 12/5/11.</p> <p>The MAR for December 2011 indicated a handwritten "D/C 11/28/11" next to the entry for Metolazone 2.5 mg, and no doses of Metolazone 2.5 mg were administered</p> <p>During interview on 12/20/11 at 1:15 p.m., the DNS indicated she was unable to locate a physician's order for discontinuation of the Metolazone 2.5 mg on 11/28/11. The DNS nodded "Yes" when asked if this was a medication error.</p> <p>This federal tag relates to Complaint IN00100950.</p> <p>3.1-35(g)(2)</p>		<p>being followed as order by their attending physician with a focus on transcription of pending labs and the discontinuation of medication The findings from these audits will be reviewed at the facility Risk Management/QA committee meeting monthly until such time as compliance has been determined, and quarterly monitoring by the RDC when completing the facility QSR has been recommended. (e) Date of compliance: 1/19/12</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155441	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/20/2011
NAME OF PROVIDER OR SUPPLIER CORYDON NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 315 COUNTRY CLUB RD CORYDON, IN47112		
(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	
F0309 SS=G	<p>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>Based on record review and interview, the facility failed to plan and/or implement the plan of care for a resident with multiple diagnoses with fluctuations in weight related to fluid retention and variations in blood chemistry. Medications were not administered as ordered, lab work was not obtained as ordered, the physician was not notified timely of critical labs, and a plan for reporting specific weight gain or loss was not established. <i>Resident D experienced a weight gain that required hospitalization for management of fluid and electrolyte balance.</i></p> <p>The deficient practice affected 1 of 1 resident reviewed related to management of weight and blood chemistry in a sample of 5. (Resident D)</p> <p>Findings include:</p> <p>The clinical record for Resident D was reviewed on 12/19/11 at 12:00 noon. The resident's diagnoses included, but were not limited to, paroxysmal atrial fibrillation, possible sick sinus syndrome, morbid obesity, congestive heart failure secondary to cor pulmonale and pulmonary hypertension, history of</p>	F0309	<p>Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth on the statement of deficiencies. This plan of correction is prepared and/or executed solely because required.</p> <p>This facility respectfully objects to the scope and severity of this deficiency and invokes the right to use the Informal Dispute Resolution process for F tag 309. We are requesting a Face to Face IDR.</p> <p>F 309 – Provide Care/Services(a) What corrective action will be accomplished for those residents found to have been affected by this practice: This information was obtained from closed record review. ISSUE #1: Medication error form has been completed. MD and family have been notified. Licensed nurse who was identified responsible for this has been re-educated on his responsibility regarding obtaining written orders for changes in medication regimen and appropriately disciplined. ISSUE # 2: Licensed nurse who was</p>	01/19/2012	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155441	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/20/2011
NAME OF PROVIDER OR SUPPLIER CORYDON NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 315 COUNTRY CLUB RD CORYDON, IN47112		
(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	
	<p>hypothyroidism, obstructive sleep apnea, Type 2 diabetes mellitus, hypertension, acute renal failure, and chronic kidney disease stage III. Medical specialists participating frequently in the resident's care included a cardiologist and nephrologist.</p> <p>The resident's care plan, dated 8/20/11, with goal date of 11/20/11, and updated 11/30/11, with goal date of 2/30 [sic]/12 indicated a problem of "Resident has edema" related to "Disease process/condition (list): CHF [congestive heart failure]" with interventions including, but not limited to, "Observe for signs/symptoms of edema or fluid overload; Report significant signs/symptoms to physician; administer/monitor effectiveness of medications per current physician's orders;" and "Monitor lab/diagnostics as ordered and report results to resident's physician."</p> <p>The resident's care plan, dated 8/20/11, with goal date of 11/20/11 and updated 11/30/11 with goal date of 2/28/12, indicated a problem of "Resident at risk for fluid volume deficit r/t fluid restriction and diuretic use" with interventions including, but not limited to, "Monitor and report to physician signs and symptoms of dehydration;</p>		<p>identified responsible for transcribing the order correctly but boxing in the wrong day on the TAR has been appropriately disciplined and re-educated on the responsibility of accuracy when transcribing orders to the TAR.MD order was obtained on the date identified to draw this lab the on 12/6/11.ISSUE # 3: Was addressed in the morning 12/7/11 when the K+ results of 6.3 was identified. MD and Responsible Party were notified. Licensed staff identified on duty during this was disciplined appropriately and received additional education of the importance of MD notification of critical lab findings.</p> <p>ISSUE # 4: Care plan for resident D has been reviewed and updated s/p hospitalization to reflect current plan of care – including parameters for notification of the physician(s) for weight gain or loss based on her daily weights.(b) How will you identify other residents having the potential to be affected by the same practice, and what corrective action will be taken: Pharmacy was contacted to complete a Chart to MAR review to ensure that current medication have appropriate MD orders with a focus of an MD orders for discontinuation of medication. A med review to identify any resident on a diuretic – to determine if it is or is not a K+ depleting</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155441	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/20/2011
NAME OF PROVIDER OR SUPPLIER CORYDON NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 315 COUNTRY CLUB RD CORYDON, IN47112		
(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	
	<p>Provide/monitor intake of diet/fluids (see current physician's orders and MAR [Medication Administration Record] Fluid restriction: 1500 cc per day; Administer/monitor effectiveness/side effects of diuretics use (see current MAR and physician's orders)."</p> <p>Physician's orders, received 9/28/11 and included in physician's recapitulation orders for October, November, and December 2011 indicated the resident was to be weighed daily.</p> <p>Physician's recapitulation orders for November 2011 included, but were not limited to, "Bumetandine 1 mg tablet [Bumex, a potassium depleting diuretic], give one tablet orally 2 times a day for edema;" "Metolazone 2.5 mg tablet [Zaroxlyn, a potassium depleting diuretic], give 1 tablet orally every Monday, Wednesday and Friday for CHF [congestive heart failure]**Note frequency**;" and "Potassium Cl [chloride] ER [extended release] 10 meq [milliequivalents] capsule, give 4 caps (40 meq) orally 3 times a day hypokalemia [low blood potassium]**Note dosage/strength**." The orders indicated the resident was to have a 1500 cc fluid restriction.</p> <p>The Daily/Weekly Weights indicated the</p>		<p>diureticand that the MD is fully aware of thecurrent drug regimen. Lab review has been completed oncurrent residents for the last 3 monthsto ensure all critical labs have been reported to the MD and responsible party notified. Audit was completed to identify any other resident(s),that are on daily weights to determine if MD hasprovided parameters for notification of gain/loss. (C) What measures will be put into place or whatsystemic changes will you make to ensure thatthe practice does not reoccur:Education was completed with the licensed nurses regarding the following:· the responsibility of accuracy when transcribing physician orders to the TAR.· the responsibility regarding obtaining written orders for changes in medication regimen before any discontinuation of a med/treatment.· licensed staff re-educated by PharmacyConsultant on the different forms ofdiuretics and its effect on electrolytes inregards to K+ replacement – andthose diuretic that are non K+ depleting.· Current license staff have been re-educated onthe responsibility of MD notification regarding critical lab.· IDT team re-educated on the importance of updating residents plan of care to reflect weight parameters if on daily weights.(d) How will the corrective actions be</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155441	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/20/2011
NAME OF PROVIDER OR SUPPLIER CORYDON NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 315 COUNTRY CLUB RD CORYDON, IN47112		
(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	
	<p>following weights in pounds : 11/28/11 - 280.2; 11/29/11 - 286.2; 11/30/11 - 291.2; 12/1/11 - 297.6; 12/2/11 - 290.4; (Nurse's Notes for 12/3/11 indicated the resident could not be weighed due to a problem with the lift.); 12/4/11 - 299.0; 12/5/11 - 301.8; 12/6/11 - 303.2; 12/7/11 - 309.2; and 12/8/11 - 307.8.</p> <p>Nurse's Notes on 11/28/11 at 12:05 p.m. indicated, "Spoke with rep [representative] at [nephrologist's office] regarding potassium deficiency, rep stated MD will phone back. This nurse will also discuss POA's [Power of Attorney's] request to increase fluid level restriction amount."</p> <p>Physician's orders for 11/28/11 indicated, "Spirolactone [diuretic that does not deplete potassium] 25 mg, give one tablet by mouth daily; D/C [discontinue] Bumex [diuretic that depletes potassium]. BMP [Basic Metabolic Profile] on 12/5/11; Increase fluid from 1500 ml/day to 1800 ml/day."</p> <p>The Medication Administration Record (MAR) for November 2011 indicated the resident received Metolazone 2.5 mg as ordered through 11/28/11. A notation on the MAR next to the Metolazone indicated, "D/C [discontinue] 11/28." The dose scheduled on the MAR for 11/30/11</p>		<p>monitored to ensure the practice will not reoccur, what quality measures will be put into place:The facility DNS/designee will conduct a weekly review of at least 5 residents x 4 weeks and every 2 weeks thereafter for two month, to ensure that:· medications that have been discontinue have a corresponding MD order,· accuracy of transcription of lab orders to the TAR,· critical lab results called to MD,· daily weights have MD notification parameters for gains/loss.The findings will be reviewed at the next Risk Management/QA meeting to determined if compliance has been achieved and the committee recommends quarter oversight by the RDCO when completing their system reviews which includes medication management, labs and plan of care.Date of compliance: 1/19/2012</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155441	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/20/2011
NAME OF PROVIDER OR SUPPLIER CORYDON NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 315 COUNTRY CLUB RD CORYDON, IN47112		
(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	
	<p>was not administered.</p> <p>Printed physician's recapitulation orders for December 2011 included, but were not limited to, "Metolazone 2.5 mg tablet, give 1 tablet orally every Monday, Wednesday and Friday for CHF [congestive heart failure]**Note frequency**." Handwritten next to the entry was "D/C 11/28/11." The December 2011 physician's orders were signed by the physician and dated 12/5/11.</p> <p>The MAR for December 2011 indicated a handwritten "D/C 11/28/11" next to the entry for Metolazone 2.5 mg, and no doses of Metolazone 2.5 mg were administered. The MAR for December 2011 indicated the physician's order for discontinuation of Bumex was followed. The MAR indicated the resident received potassium chloride as ordered through 12/6/11.</p> <p>During interview on 12/20/11 at 1:15 p.m., the DNS indicated she was unable to locate a physician's order for discontinuation of the Metolazone 2.5 mg on 11/28/11. The DNS nodded "Yes" when asked if this was a medication error.</p> <p>The next entry in the Nurse's Notes related to resident's weight gain from 11/28/11 to 12/6/11 was 12/6/11 at 2:45</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155441	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/20/2011
--	---	--	---

NAME OF PROVIDER OR SUPPLIER CORYDON NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 315 COUNTRY CLUB RD CORYDON, IN47112
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
	<p>p.m. and indicated, "Phoned Dr. [name of nephrologist] r/t weight gain. New orders rec'd [received]."</p> <p>During interview on 12/20/11 at 1:15 p.m., the Director of Nursing Services (DNS) indicated the physician's order for the Basic Metabolic Profile on 12/5/11 was transcribed incorrectly onto the Treatment Administration Record, and the test was not obtained as ordered on 12/5/11.</p> <p>Physician's orders on 12/6/11 at 2:45 p.m., indicated, "Mag [magnesium] level; CBC [Complete Blood Count] [symbol for no] diff [differential]; BMP [Basic Metabolic Profile]; [symbol for change] fluid restriction to: 1500 cc/24 [symbol for hours] day...." The order indicated lab results should be called to the nephrologist.</p> <p>A lab report for a BMP (Basic Metabolic Profile) indicated the final report to the facility was on 12/7/11 at 3:00 a.m. Results of the blood work included, but were not limited to, "Potassium 6.3 RCH [repeat critical high]" with the normal range of 3.5 to 5.3 meq/L [liter]</p> <p>Nurse's Notes on 12/7/11 at 3:10 a.m., indicated, "BMP results faxed to MD. [Symbol for no] critical's...."</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155441	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/20/2011
--	---	--	---

NAME OF PROVIDER OR SUPPLIER CORYDON NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 315 COUNTRY CLUB RD CORYDON, IN47112
---	--

(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
	<p>During interview on 12/20/11 at 11:30 a.m., the Administrator indicated the nurse did not call the physician to report the critical high potassium level. The Administrator indicated if the nurse could not reach the resident's physician, she should call the on-call physician, and if she could not reach the on-call physician, she should call the Director of Nursing Services or the Administrator.</p> <p>A physician's order, dated 12/7/11 at 9:30 a.m. indicated, 1. Hold K+ [potassium chloride] until further notice 2. Give 1 dose Kayexalate 30 g [grams] [decreases serum potassium level] po [by mouth] 3. STAT [immediate] BMP [Basic Metabolic Profile] & call [name of resident's nephrologist] [symbol for with] results."</p> <p>A physician's order, dated 12/7/11 at 3:30 p.m., indicated, "1) D/C [discontinue] K+ [potassium]; 2) BMP on 12/9/11. Call results to [name of nephrologist]" with "Indication- DX [diagnosis] Hyperkalemia [high blood potassium]."</p> <p>Nurse's Notes for 12/7/11 and 12/8/11 indicated numerous conversations between facility staff, the resident's POA, and the nephrologist's office related to obtaining an appointment for the resident</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155441	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/20/2011
NAME OF PROVIDER OR SUPPLIER CORYDON NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 315 COUNTRY CLUB RD CORYDON, IN47112		
(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	
	<p>to be seen by the nephrologist. A Nurse's Note for 12/8/11 at 3:05 p.m., indicated, "...Agreed [with POA] to contact Dr. [name of cardiologist] r/t weight gain et [and] change of meds [medications] from renal physician. Faxed [name of cardiologist], called et spoke [symbol for with] [name of cardiologist's] nurse, received call back [symbol for with] order for BMP 12/9/11. [Name of cardiologist's nurse] stated she will show [name of cardiologist] all documents faxed: MAR, labs, November et December weights...."</p> <p>A Nurse's Note for 12/9/11 at 10:00 a.m. indicated the cardiologist's office notified the facility that the resident would be directly admitted to the hospital. Nurse's Notes for 12/9/11 at 1:20 p.m. indicated the ambulance arrived to transport the resident to the hospital.</p> <p>The hospital History and Physical, dated 12/9/11, indicated, "History of Present Illness: ...transferred from the nursing home where she has had weight gain for the last 2-3 weeks and reported to her cardiologist, and she was directly admitted here for diuresis and workup....Review of Systems: Weight gain without any shortness of breath or chest pain....Assessment/Plan: Patient with chronic morbid obesity with history of congestive heart failure, coronary artery</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155441	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/20/2011
NAME OF PROVIDER OR SUPPLIER CORYDON NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 315 COUNTRY CLUB RD CORYDON, IN47112		
(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	
	<p>disease and chronic pulmonary disease with increased weight gain in the last couple of weeks. She is here for diuresis and evaluation for the congestive heart failure...."</p> <p>During interview on 12/20/11 at 12:30 p.m., the Director of Nursing Services (DNS) showed the facility's weight book, located in the nurse's station, and indicated the restorative aides are responsible for weighing residents. The DNS indicated the aides are very good to reweigh residents if weights seem inaccurate. The DNS also indicated the aides let the nurse know if a resident is gaining or losing weight.</p> <p>During interview on 12/20/11 at 1:15 p.m., the Administrator and Director of Nursing Services and Administrator were interviewed. The DNS indicated Resident D's care plan did not include parameters for notification of the physician for Resident D's weight gain or loss, even though the resident was weighed daily. The DNS indicated the Registered Dietitian is in the facility two times a month and reviews residents' weights. The Administrator and DNS also indicated residents' weights are discussed at the morning meeting of staff, when the 24 hour report is reviewed, and that Resident D's weight had been discussed at</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155441	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/20/2011
NAME OF PROVIDER OR SUPPLIER CORYDON NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 315 COUNTRY CLUB RD CORYDON, IN47112		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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	
F0333 SS=D	<p>the morning meetings.</p> <p>This federal tag is related to Complaint IN00100950.</p> <p>3.1-37(a)</p> <p>The facility must ensure that residents are free of any significant medication errors. Based on record review and interview, the facility failed to ensure a medication was not discontinued without a physician's order to discontinue for 1 of 5 residents reviewed related to medication administration in a sample of 5. (Resident D) Resident D experienced a critically elevated blood potassium level which</p>	F0333	<p>Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth on the statement of deficiencies. This plan of correction is prepared and/or executed solely because required. F 333 Significant</p>	01/19/2012	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155441	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/20/2011
NAME OF PROVIDER OR SUPPLIER CORYDON NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 315 COUNTRY CLUB RD CORYDON, IN47112		
(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	
	<p>required treatment with medication.</p> <p>Findings include:</p> <p>The clinical record for Resident D was reviewed on 12/19/11 at 12:00 noon.</p> <p>Physician's recapitulation orders for November 2011 included, but were not limited to, "Bumetandine 1 mg tablet [Bumex, a potassium depleting diuretic], give one tablet orally 2 times a day for edema;" "Metolazone 2.5 mg tablet [Zaroxlyn, a potassium depleting medication], give 1 tablet orally every Monday, Wednesday and Friday for CHF [congestive heart failure]**Note frequency**;" and "Potassium Cl [chloride] ER [extended release] 10 meq [milliequivalents] capsule, give 4 caps (40 meq) orally 3 times a day hypokalemia [low blood potassium]**Note dosage/strength**."</p> <p>Physician's orders, dated 11/28/11, included, but were not limited to, "Spirolactone [diuretic that does not deplete potassium] 25 mg, give one tablet by mouth daily" and D/C [discontinue] Bumex [diuretic that depletes potassium]." Next to the word Bumex was the word "and" with a line drawn through it.</p>		<p>Medication Error (a) What corrective action(s) will be accomplished for those residents found to have been affected by the practice: This information was taken from closed record review. · Medication error form has been completed, · MD and family have been notified · Licensed nurse who was identified responsible for this has been re-educated on his responsibility regarding obtaining written orders for changes in medication regimen and appropriately disciplined. (b) How you will identify other residents having potential to be affected by the same practice and what corrective action will be taken: Pharmacy was contacted to complete a Chart to MAR review to ensure that current medication have appropriate MD orders with a focus of an MD orders for discontinuation of medication. (c) What measures will be put into place or what systematic changes you will make to ensure that the practice does not recur: Education was completed with the licensed nurses regarding the requirement to obtain MD orders for medication (s) prior to discontinuation. (d) How the corrective action(s) will be monitored to ensure the practice will not recur, i.e., what quality assurance</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155441		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/20/2011	
NAME OF PROVIDER OR SUPPLIER CORYDON NURSING AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 315 COUNTRY CLUB RD CORYDON, IN47112			
(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			
	<p>Documentation failed to indicate the physician's order for Metolazone was discontinued.</p> <p>The Medication Administration Record (MAR) for November 2011 indicated the resident received the Metolazone 2.5 mg as ordered through 11/28/11. A notation on the MAR next to the Metolazone indicated, "D/C [discontinue] 11/28." The dose scheduled on the MAR for 11/30/11 was not administered.</p> <p>Printed physician's recapitulation orders for December 2011 included, but were not limited to, "Metolazone 2.5 mg tablet, give 1 tablet orally every Monday, Wednesday and Friday for CHF [congestive heart failure]**Note frequency**." Handwritten next to the entry was "D/C 11/28/11." The December 2011 physician's orders were signed by the physician and dated 12/5/11.</p> <p>The MAR for December 2011 indicated a handwritten "D/C 11/28/11" next to the entry for Metolazone 2.5 mg, and no doses of Metolazone 2.5 mg were administered. The MAR for December 2011 indicated the physician's order for discontinuation of Bumex was followed. The MAR indicated the resident received potassium chloride as ordered through 12/6/11.</p>		<p>program will be put into place: The facility DNS/designee will conduct a weekly review of at least 5 residents x 4 weeks and every 2 weeks thereafter for two month, to ensure that medications that have been discontinue have a corresponding MD order. The findings will be reviewed at the next Risk Management/QA meeting to determined if compliance has been achieved and the committee recommends quarter oversight by the RDCO when completing their system reviews which includes medication management. Date of compliance: 1/19/2012</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155441	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/20/2011
NAME OF PROVIDER OR SUPPLIER CORYDON NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 315 COUNTRY CLUB RD CORYDON, IN47112		
(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	
	<p>A lab report for a BMP (Basic Metabolic Profile) indicated the final report to the facility was on 12/7/11 at 3:00 a.m. Results of the blood work included, but were not limited to, "Potassium 6.3 RCH [repeat critical high]" with the normal range of 3.5 to 5.3 meq/L [liter]</p> <p>A physician's order, dated 12/7/11 at 9:30 a.m. indicated, 1. Hold K+ [potassium chloride] until further notice 2. Give 1 dose Kayexalate 30 g [grams] [decreases serum potassium level] po [by mouth] 3. STAT [immediate] BMP [Basic Metabolic Profile] & call [name of resident's nephrologist] [symbol for with] results."</p> <p>During interview on 12/20/11 at 1:15 p.m., the Director of Nursing Services (DNS) indicated she was unable to locate a physician's order for discontinuation of the Metolazone 2.5 mg on 11/28/11. The DNS nodded "Yes" when asked if this was a medication error.</p> <p>This federal tag relates to Complaint IN00100950.</p> <p>3.1-25(b)(9) 3.1-48(c)(2)</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155441	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/20/2011
NAME OF PROVIDER OR SUPPLIER CORYDON NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 315 COUNTRY CLUB RD CORYDON, IN47112		
(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	
F0387 SS=D	<p>The resident must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 days thereafter.</p> <p>A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required.</p> <p>Based on record review and interview, the facility failed to ensure physician visits were made every 60 days for 1 of 1 resident (Resident E) and were made in a timely manner for 1 of 1 resident (Resident F) in a sample of 5 residents reviewed related to physician visits.</p> <p>Findings include:</p> <p>1. Review of the clinical record for Resident E on 12/19/2011 at noon, indicated the resident had diagnoses which included, but were not limited to, Alzheimer dementia with disturbance of mood and hypertension.</p> <p>Review of the physician visits for 2011 indicated the last progress note/visit made was on 9/28/2011. The December 2011 monthly physician orders were noted to have been signed by the physician on 12/5/2011.</p> <p>During the daily exit meeting with the Administrator, the Director of Nursing Services and the Minimum Data Set</p>	F0387	<p>Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth on the statement of deficiencies. This plan of correction is prepared and/or executed solely because required.</p> <p>F 387 Physician Visits</p> <p>(a) What corrective action(s) will be accomplished for those residents found to have been affected by the practice: Resident's E and F - primary physician(s) was notified of the requirement that they are to be seen at least every 60 days. MD(s) have completed a current progress note.</p> <p>(b) How you will identify other residents having potential to be affected by the same practice and what corrective action will be taken: An audit was completed reviewing all primary physician progress notes with a focus of those admitted within the last 90 days to identify that they have been seen every 30 days (for the first 90 days) and for the LTC resident's that they have been seen within the last 60 days to assure that all charts support a timely physician visit and that progress notes are current. Any physician found to be out of regulatory compliance was notified of this requirement and an onsite visit to provide facility with a current progress note was requested.</p>	01/19/2012	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155441	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/20/2011
NAME OF PROVIDER OR SUPPLIER CORYDON NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 315 COUNTRY CLUB RD CORYDON, IN47112		
(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	
	<p>[MDS] Coordinator on 12/19/2011 at 5:20 p.m., the DNS and the MDS Coordinator indicated they were not sure why the physician did not see the resident when visits were made to 2 other residents on 12/5/2011. The Administrator also indicated he would contact the physician's office to see if the note was not still in the office by mistake.</p> <p>On 12/20/2011 at 1:10 p.m., the Administrator indicated he was unable to locate any physician visit note for Resident E after 9/28/2011. At 1:20 p.m., the MDS Coordinator also indicated she was unable to locate a physician note after 9/28/2011.</p> <p>2. Review of the clinical record for Resident F on 12/19/2011 at 2:00 p.m., indicated the resident had diagnoses which included, but were not limited to, diabetes mellitus, essential hypertension, chronic obstructive pulmonary disease, anemia, and gastroesophageal reflux disease.</p> <p>Review of the 2011 physician visits indicated the resident was seen on 7/21/2011, 9/21/2011 and again on 12/13/2011 (22 days after the preceding visit).</p> <p>During an interview with the MDS</p>		<p>(c) What measures will be put into place or what systematic changes you will make to ensure that the practice does not recur: Medical records designee will track the due dates for physician visits and notify physicians by letter, phone, and/or fax of resident visit due dates. The Medical records designee will notify the DNS of regulatory compliance issues related to physician's visits. Nurse's reviewing the monthly POS change-over process will review progress notes for physician visit compliance and notify the DNS of regulatory compliance issues related to physician's visits. The MDSC will review progress notes during the completion of MDS assessments and notify the DNS regulatory compliance issues related to physician's visits. Physician's found during the above auditing and review process to be out of regulatory compliance with physician's visits will receive a phone call by the DNS or designee requesting an onsite visit and written progress note to occur as soon as reasonably possible. If a physician is determined to be unable to meet regulatory requirements for physician's visits, the Medical Director will be notified and a suitable alternative developed.</p> <p>(d) How the corrective action(s) will be monitored to ensure the practice will not recur, i.e., what quality assurance program will be put into place: The DNS or designee will randomly monitor 5 charts weekly for the next 4 weeks and then bi-monthly there after to identify any non-compliance of physician visits for immediate corrective action. Report of these audits will be discussed at the monthly QA/Risk Management to determine when</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155441	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/20/2011
NAME OF PROVIDER OR SUPPLIER CORYDON NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 315 COUNTRY CLUB RD CORYDON, IN47112		
(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	
	<p>Coordinator on 12/19/2011 at 5:10 p.m., she indicated she was responsible as the Medical Records clerk also and that the procedure was that the computer would pop out a list of residents who had physician visits due for that month. She would then notify each physician of the names of the residents who had to be seen by a certain date. She indicated if she had not heard back from the physician after a certain time, she would notify the office again to remind him/her that a visit was coming due or if it was past due.</p> <p>On 12/20/2011 at 1:00 p.m., the Administrator presented a copy of the facility's current policy on "Physician Visits". Review of this policy at this time included, but was not limited to, "Policy Statement: The Attending Physician must make visits in accordance with applicable state and federal regulations...Alternate Schedule of Visits: 2. After the first ninety (90) days, if the Attending Physician determines that a resident need not be seen by him/her every thirty (30) days, an alternate schedule of visits may be established, but not to exceed every sixty (60) days..."</p> <p>This federal tag relates to Complaint IN00100950.</p> <p>3.1-22(d)(1)</p>		<p>compliance has been achieved and the committee recommends Quarterly oversight by the RDCO when completing their QSR which reviews physician visits,</p> <p>(e) Date of compliance: 1/19/12</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155441	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/20/2011
NAME OF PROVIDER OR SUPPLIER CORYDON NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 315 COUNTRY CLUB RD CORYDON, IN47112		
(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	
F0502 SS=D	<p>3.1-22(d)(2)</p> <p>The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services.</p> <p>Based on record review and interview, the facility failed to ensure its laboratory service provider called the facility when a resident's potassium level was at a critical level for 1 of 5 residents reviewed related to lab services in a sample of 5. (Resident D)</p> <p>Findings include:</p> <p>The clinical record for Resident D was reviewed on 12/19/11 at 12:00 noon.</p> <p>A Physician's Telephone Order, dated 12/6/11, included, but was not limited to, "BMP [Basic Metabolic Profile]."</p> <p>A lab report for a BMP (Basic Metabolic Profile) for a specimen collected 12/6/11 at 3:35 p.m., indicated the final report to the facility was on 12/7/11 at 3:00 a.m. Results of the blood work included, but were not limited to, "Potassium 6.3 RCH [repeat critical high]" with the normal range of 3.5 to 5.3 meq/L [liter]. Documentation on the lab report and in Nurse's Notes for 12/7/11 failed to</p>	F0502	<p>Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth on the statement of deficiencies. This plan of correction is prepared and/or executed solely because required.</p> <p>F502 Laboratory Services</p> <p>(A)What corrective actions will be accomplished for those residents found to have been affected by the practice?</p> <p>LPN identified who received the fax for resident D on 12/7/11 at 3 AM and did not identified that one of the labs was listed as "critical" received a write-up as a disciplinary action.</p> <p>This LPN has since received further education on lab results and the need for MD notification for "critical labs".</p> <p>A meeting was conducted between the facility and the VP of clinical for their providing lab. Review of the contract with a focus on "critical lab" reporting was discussed to ensure that the procedure will be followed.</p>	01/19/2012	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155441	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/20/2011
NAME OF PROVIDER OR SUPPLIER CORYDON NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 315 COUNTRY CLUB RD CORYDON, IN47112		
(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	
	<p>indicate the lab called facility staff to notify of the critically high potassium level.</p> <p>On 12/19/11 at 3:15 p.m., the Administrator provided copy of documentation related to services provided by the facility's lab service provider. Included in the documentation was a "Critical Call List," listing tests and results. The list included, "Potassium Critical Results [symbol for equal to or less than] 2.8 [symbol for equal to or greater than 6.2]."</p> <p>During interview on 12/20/11 at 11:30 a.m., the Administrator indicated the lab service had not called the facility to notify of Resident D's critical lab value. The Administrator indicated he planned a meeting with a lab service representative to discuss the problem.</p> <p>This federal tag relates to Complaint IN00100950.</p> <p>3.1-49(a)</p>		<p>(b) How other residents having the potential to be affected by the same practice will be identified and what corrective actions will be taken? Lab review has been completed on current residents for the last 3 months to ensure all critical labs have been reported to the MD and responsible party notified.</p> <p>(c) What measures will be put into place or what systemic changes will be made to ensure that the practice does not recur? License staff have been re-educated on the components of this tag and their responsibility of MD notification regarding critical lab results.</p> <p>(d) How will the corrective actions be monitored to ensure the practice will not recur and what quality assurance program will be put into place? The monitoring of this tag will be the joint responsibility of the DNS/MDS/designee as they review:</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155441	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/20/2011
NAME OF PROVIDER OR SUPPLIER CORYDON NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 315 COUNTRY CLUB RD CORYDON, IN47112		
(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	
F0514 SS=D	<p>The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>Based on record review and interview, the facility failed to ensure documentation was complete and accurate for 1 of 5</p>	F0514	<p>Weekly lab (for the next 4 weeks then bi-weekly X 2 months) for appropriate MD notification of critical lab levels any identified issues will be immediately addressed for corrective action.</p> <p>The report of these findings will be presented at the Risk Management/QA Committee meeting to determine if compliance has been achieved and quarterly monitoring by the RDCO when completing their QSR which included review of these categories,</p> <p>(e) Date Certain: 01/19/2012</p> <p>Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth on the statement of deficiencies.</p>	01/19/2012	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155441	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/20/2011
NAME OF PROVIDER OR SUPPLIER CORYDON NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 315 COUNTRY CLUB RD CORYDON, IN47112		
(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	
	<p>residents reviewed related documentation in the clinical record in a sample of 5. (Resident D)</p> <p>Findings include:</p> <p>The clinical record for Resident D was reviewed on 12/19/11 at 12:00 noon.</p> <p>A. The Nursing Admission Data Review indicated the date of readmission from the hospital was 6/8/11 at 8:45 p.m.</p> <p>The Nurse's Note, on 6/9/11 at 1:40 a.m., indicated the resident complained of pain in the left knee, and a "bruise approx [approximately] 7 in [inches] log is visible. Resident C/O [complained of] pain when ever leg is touched or moved. resident said injury happened during assisted fall to the floor while transferring from BSC [bedside commode] to bed....MD notified...." Nurse's Notes indicated the physician ordered an x-ray of the left knee, and a subsequent note indicated the resident had no fracture.</p> <p>Documentation failed to indicate information related to the fall, until the resident reported the fall to the nurse on the next shift, when she experienced pain.</p> <p>A late-entry Nurse's Note, dated 6/15/11 at 1:45 p.m., indicated, "On 6/8/11 at</p>		<p>This plan of correction is prepared and/or executed solely because required.</p> <p>F – 514 Records-Complete/Accurate/Accessible</p> <p>(a) What corrective action(s) will be accomplished for those residents found to have been affected by the practice:</p> <p>ISSUE A: This information was taken from a closed record review which also supports that the next shift nurse did notify the MD and family. The licensed nurse who was identified in as not documenting the fall when it actually occurred received a disciplinary action.</p> <p>ISSUE B: This information was taken from a closed record review – the licensed nurse identified received a disciplinary action.</p> <p>(b) How you will identify other residents having potential to be affected by the same practice and what corrective action will be taken:</p> <p>Event records for the last 6 months were reviewed to identify any documentation that was not completed timely – this also included timely review for MD/Responsible Party notification. Review of current resident's lab orders over the last 6 months was completed with a focus that labs were obtained on the date as</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155441	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/20/2011
NAME OF PROVIDER OR SUPPLIER CORYDON NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 315 COUNTRY CLUB RD CORYDON, IN47112		
(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	
	<p>approx 2100 [9:00 p.m.], resident was transferring to bed via walker and assist X 3 (This nurse [LPN #5], [name of CNA #16], CNA, and [name of CNA #8], CNA) when resident became anxious and yelled out, 'My foot is giving out.' [name of CNA #16] and this nurse reassured resident, but resident insisted standing was not possible. This nurse positioned W/C [wheel chair] behind resident. [Name of CNA #16], CNA, and this nurse advised resident to allow us to get her in W/C. Resident then stated, 'I'm going down.' This nurse and [Name of CNA #16] assured resident of her being held and prevented from incident. Resident then let go of walker. [Name of CNA #16], CNA, [Name of CNA #8], CNA, and this nurse lowered resident to floor. Resident denied pain, just stated she was nervous. Resident was visibly anxious, but upon assessment no S/S [signs and symptoms] of injury was noted."</p> <p>During interview on 12/20/11 at 1:00 p.m., the Administrator reviewed the Nurse's Notes and indicated the nurse did not document the resident's fall at the time of the fall.</p> <p>During interview on 12/20/11 at 2:20 p.m., the Director of Nursing Services (DNS) indicated she would expect the nurse to assess and document the</p>		<p>order by the MD. If not obtained the charts were reviewed to ensure there was MD notification as to the delay and a updated order if needed.</p> <p>(c) What measures will be put into place or what systematic changes you will make to ensure that the practice does not recur:</p> <p>Education was completed with the licensed nurses regarding complete , accurate and timely documentation regarding falls, along with MD/responsible party notification.. Education was completed with the licensed nurses regarding transcription of lab orders to the TAR – to reflect actual order and date scheduled to be drawn. Review of 24-hr chart checks as a cross check was included in this training</p> <p>(d) How the corrective action(s) will be monitored to ensure the practice will not recur, i.e., what quality assurance program will be put into place:</p> <p>The monitoring of this tag will be the joint responsibility of the DNS/MDS/designee as they review:</p> <ul style="list-style-type: none"> -Fall events – during standup meeting for timely documentation of the fall in the clinical record and MD/Responsibility party notification. This will be on-going. -Weekly lab reviews (for the next 4 weeks then bi-weekly X 2 months) of residents lab 		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155441	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/20/2011
NAME OF PROVIDER OR SUPPLIER CORYDON NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 315 COUNTRY CLUB RD CORYDON, IN47112		
(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	
	<p>assessment of the resident, including vital signs, movement/range of motion, and pain while the resident was still on the floor after a fall.</p> <p>B. Physician's orders, dated 11/28/11, included, but were not limited to, "BMP [Basic Metabolic Profile] on 12/5/11." Documentation in Nurse's Notes and lab reports failed to indicate the BMP was obtained on 12/5/11.</p> <p>During interview on 12/20/11 at 1:15 p.m., the Director of Nursing Services (DNS) indicated the physician's order for the lab test was transcribed incorrectly onto the Treatment Administration Record, so the test was not obtained as ordered on 12/5/11. The DNS indicated the nurse who transcribed the order had received education related to the transcription error.</p> <p>This federal tag relates to Complaint IN00100950.</p> <p>3.1-50(a)(1) 3.1-50(a)(2)</p>		<p>orders that the orders have been transcribed correctly. The report of these findings will be presented at the Risk Management/QA Committee meeting to determine if compliance has been achieved and quarterly monitoring my the RDCO when completing their QSR which included these category reviews.,</p> <p>Date of compliance: 1/19/2012</p>		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/12/2012

FORM APPROVED

OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155441	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/20/2011
NAME OF PROVIDER OR SUPPLIER CORYDON NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 315 COUNTRY CLUB RD CORYDON, IN47112		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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	