

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155486	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  10/22/2013
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NAME OF PROVIDER OR SUPPLIER  MIDDLETOWN NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 131 S 10TH ST MIDDLETOWN, IN 47356
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F000000	<p>This visit was for the Investigation of Complaint IN00137942.</p> <p>Complaint IN00137942 - Substantiated. Federal/state deficiency related to the allegations is cited at F279.</p> <p>Survey dates: October 21 and 22 , 2013</p> <p>Facility number: 000343 Provider number: 155486 AIM number: 100289600</p> <p>Survey team: Penny Marlatt, RN</p> <p>Census bed type: SNF/NF: 25 Total: 25</p> <p>Census Payor type: Medicare: 4 Medicaid: 14 Other: 7 Total: 25</p> <p>Sample: 3</p> <p>This deficiency reflects state findings in accordance with 410 IAC 16.2.</p>	F000000	<p>This Plan of Correction is submitted to serve as a Credible Allegation of compliance in association with stated completion dates. Preparation and/or execution of this plan of correction does not constitute an admission of agreement by the provider of conclusion set facts on the statement of deficiencies. The Plan of Correction is prepared and/or executed solely because it is required by State and Federal Laws.</p>	
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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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F000279 SS=D	<p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>Based on interview and record review, the facility failed to develop and/or revise the resident's plan of care for 2 of 3 residents, in a sample of 3, reviewed for care plans related to falls and bruises for medications commonly referred to as "blood thinners." This deficient practice has the potential to adversely affect resident care due to lack of acknowledgement of potential ill side effects. (Resident #A and Resident #B)</p> <p>Findings include:</p>	F000279	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. Resident A expired 10/21/2013. Resident B's care plan has been revised to include side effects for aspirin including bruising and bleeding (see Attachment #1). How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken. All resident's medication orders have been audited and any antiplatelet and anticoagulant drugs commonly referred to as "blood thinners" have been added	11/05/2013	

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	<p>1. Resident #A's clinical record was reviewed on 10-21-13 at 11:10 a.m. Her diagnoses included, but were not limited to, Alzheimer's dementia, debility, pneumonia, congestive heart failure, atrial fibrillation and fall resulting in a subdural hematoma on 10-8-13.</p> <p>Review of Resident #A's medications indicated her attending physician initiated Coumadin (an anti-coagulant or blood thinner) therapy of 1 milligram (mg) daily by mouth on 8-19-13, approximately 4 days after admission to the facility. The physician ordered the medication be monitored with twice weekly blood tests of PT/INR (prothrombin and international normalized ratio) levels to detect bleeding tendencies.</p> <p>Review of the resident's plans of care indicated on 8-22-13, a plan of care was developed for "Potential for side effects due to Coumadin med use." It indicated the goals for this identified problem as, "Resident will receive med as ordered and will be free of negative side effects from Coumadin use through next review." The interventions or approach to meet the goals were indicated as, "(1) Meds as ordered. (2) Labs as ordered. (3)</p>		<p>to care plans along with side effects or precautions to be observed. (see attachment #2-15). What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur. All nurses have been inserviced when getting orders for any medication commonly referred to as "blood thinners" to make out temporary care plan at the time order is obtained with medication and common side effects and precautions to be observed. (see attachment #16) This will be put with appropriate resident care plans. The temporary care plan will then be added to permanent care plan within 7 days during weekly care plan meeting. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place. This will be monitored by the D.O.N. all charts will be audited for new orders daily for 1 month and monthly thereafter. This will be incorporated into quarterly Quality Assurance meeting during drug review portion of meeting. By what date the systemic changes will be completed. All changes will be completed by 11/5/2013. Respectfully requesting paper compliance for F279.</p>	

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	<p>Consult with MD as ordered." The approach or interventions did not indicate any side effects, negative or positive, facility staff should observe for in the resident while taking this medication.</p> <p>In interview with the MDS Coordinator on 10-22-13 at 9:30 a.m., she indicated, "the care plan for Coumadin should include what precautions or side effects to look for." She indicated Resident #A's care plan did not include those items.</p> <p>2. Resident #B's clinical record was reviewed on 10-21-13 at 2:03 p.m. It indicated her diagnoses included, but were not limited to, dementia, congestive heart failure and coronary artery disease.</p> <p>Review of Resident #B's recapitulation orders for October, 2013 indicated she was to receive aspirin 81 mg daily by mouth. Review of the resident's plans of care indicated a lack of any plan of care for the use of the aspirin, an anti-platelet medication commonly used to "thin the blood" of persons with heart problems. "Nursing Drug Spectrum 2010" indicated persons taking this medication should be educated regarding or monitored for unusual</p>			

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	<p>bleeding or bruising, as well as for salicylate (aspirin) toxicity such as rapid breathing, irritability, headache, vomiting, seizures and respiratory failure.</p> <p>In interview with the MDS Coordinator on 10-22-13 at 9:30 a.m., she indicated she had not written a care plan for the use of aspirin for Resident #B. She indicated she had never written a care plan for aspirin therapy.</p> <p>On 10-22-13 at 12:15 p.m., the Director of Nursing provided a copy of a policy entitled, "Planning for Delivery of Care." This policy was indicated to be the current policy in use by the facility. It indicated, "...the plan of care takes into account all the physical, psychological and social characteristics of the resident...This assessment is an appraisal to determine the resident's potential by evaluating his needs, strengths, problems and identifies health care priorities...When established, the plan targets significant strengths, problems and needs; develops goals to meet hoped for accomplishments, and specifies the inter-disciplinary approaches to achieving these goals...As this tool serves as the guide for effective care, it should be</p>						

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	<p>an ongoing reflection of the resident and all charting should relate to this process...The health care plan is an ongoing written record of the combined efforts by all disciplines to maximize the resident's potential, restore health, and brings residents to their optimum levels of functioning..."</p> <p>This Federal tag relates to Complaint IN00137942.</p> <p>3.1-35(a) 3.1-35(b)(1)</p>			