STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155698	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 11/04/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHANY POINTE HEALTH CAMPUS	1707 BETHANY RD ANDERSON, IN 46012

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F000000	This visit was for the Investigation of Complaint IN00138691. Complaint IN00138691 - Substantiated. Federal/State deficiencies related to the allegations are cited at F282 and F505. Survey dates: November 1 and 4, 2013 Facility number: 011045 Provider number: 155698 AIM number: 200380790 Surveyor: Betty Retherford RN Census bed type: SNF/NF: 16 SNF: 52: Residential: 35 Total: 103 Census payor type: Medicare: 32 Medicaid: 8 Other: 63 Total: 103 Sample: 3 These deficiencies also reflect state	F000000	Preparation or execution of this plan of correction does not constitute admission or agreement of provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. The Plan of Correction is prepared and executed solely because it is required by the position of Federal and State Law. The Plan of Correction is submitted in order to respond to the allegation of noncompliance cited during the complaint survey on November 4th, 2013. Please accept this plan of correction as the provider's credible allegation of compliance. The provider respectfully requests a desk review with paper compliance to be considered in establishing that the provider is in substantial compliance.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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	findings cited in accordance with 410 IAC 16.2. Quality review completed by Debora Barth, RN.			

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F000282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.			
	Based on record review and interview, the facility failed to ensure the nursing staff contacted the laboratory services provider and promptly obtained tests as ordered by the physician and failed to follow-up with the physician when a response was not obtained in regards to a faxed lab test for 2 of 3 residents reviewed for laboratory testing in a sample of 3. (Resident #B and #C) Findings include: 1.) The clinical record for Resident #B was reviewed on 11/1/13 at 9:15 a.m. Diagnoses for the resident included, but were not limited to, Metastatic Adenocarcinoma of the lung, diabetes mellitus, and deep vein thrombosis of the left leg. A current individual plan report, to be reviewed next on 1/22/14, indicated Resident #B was on medications to thin her blood related to her diagnoses of deep vein thrombosis.	F000282	F 282 Corrective actions accomplished for those residents found to be affected by the alleged deficient practice: Resident B has been discharged. Resident C - MD was notified of the missed lab, new order received to draw CBC, results communicated to the MD. Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken: DHS or designee will review all resident lab orders for past 30 days to ensure the nursing staff contacted the laboratory services provider, promptly obtained the tests as ordered by the MD and documented follow-up with the MD if a response was not obtained from previous notification. Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur: DHS or designee will re-educate the Licensed Nurses on the following campus guidelines: 1. Lab Tracking 2. Physician Notification How the corrective measures will be monitored to ensure the alleged deficient practice does not	12/04/2013

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	The plan indicated the staff were to obtain labs as ordered and report the lab results to the physician. The clinical record indicated Lovenox (a subcutaneous medication) was given to thin the blood on 9/27/13 at 100 milligrams (mgs) daily. The Lovenox medication was decreased to 80 mgs daily on 10/4/13 and the resident was to begin receiving Coumadin (an oral medication given to thin the blood) 5 mg daily on 10/5/13. The resident was to have a PT/INR (prothrombin level and international ratio-a test done to check the thinness of the blood) on 10/7/13. The lab test report, dated 10/7/13, indicated the thinness of the resident's blood was not yet in therapeutic range and the physician was notified of the test results on 10/8/13. A physician's order, dated 10/8/13, indicated the physician wanted another PT/INR blood test drawn on 10/10/13. No medication change was made at that time. The clinical record indicated the PT/INR blood tests were completed as ordered on 10/10/13. A notation on the lab indicated the report was faxed to the physician on 10/10/13. A		recur: The following audits for 5 residents per hallway will be conducted by the DHS or designee 3 times per week times 8 weeks, then monthly times 4 months to ensure compliance: 1). resident lab orders to ensure the nursing staff contacted the laboratory services provider 2). ensure the lab test was promptly obtained as ordered by the MD 3). documented follow-up with the MD if a response was not obtained from previous notification. The results of the audit observations will be reported, reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation.	

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	stamp on the lab indicated "no" under the section of "orders received". The lab tests indicated the resident's INR level was 1.7 (reference interval 0.8 - 1.2) and the prothrombin level was 18.8 (reference interval 9.1-12.0). The clinical record lacked any information related to possible changes in the dosage of the resident's Coumadin medication or when the physician wanted another PT/INR lab test completed related to the resident recently being put on Coumadin therapy. During an interview with LPN #1 (the nurse who faxed the 10/10/13 labs to the oncologist), on 11/1/13 at 2:10 p.m., he indicated he had first called the oncologist, but they wanted to see a "hard copy" of the lab report, so he faxed it to them. He indicated he could not remember if he had filed the lab test in the resident's clinical record or put it back into a folder on the unit where lab test reports stay until they have been completely followed up on. The clinical record indicated the resident continued to receive the Lovenox medication 80 mgs daily and the Coumadin medication 5 mg daily through 10/20/13. On 10/20/13, the resident developed a nose bleed and			

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	she was sent to the emergency room for treatment. Hospital admission records, dated 10/20/13, indicated the resident was admitted with a nosebleed secondary to Coumadin toxicity with an INR level "around 9.8". She returned to the facility on 10/22/13. 2.) The clinical record for Resident #C was reviewed on 11/1/13 at 10:30 a.m. Diagnoses for the resident included, but were not limited to, aftercare following total right knee replacement and hypertension. A nurse note entry, dated 9/26/13 at 5 p.m., indicated the resident had been seen by her physician and new orders had been received. A physician's order, dated 9/26/13, indicated the resident was to have CBC (complete blood count) and CMP (complete metabolic profile) lab tests completed. The clinical record lacked any information related to the CBC or CMP lab tests having been completed as ordered from 9/26/13 through 10/9/13. During an interview with the DoN, on 11/1/13 at 3:35 p.m., she indicated			

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	the 9/26/13 order for the CBC and CMP lab tests had been missed by the nursing staff and the lab tests had not been drawn until they were reordered on 10/10/13. 3.) Review of the current facility policy, dated 11/22/08, provided by the DoN on 11/4/13 at 9:20 a.m., titled "Lab Tracking Guidelines", included, but was not limited to, the following: "Purpose: 1. When an order is received for a laboratory test it shall be added to the "Lab Tracking Log." 2. The nursing staff or person designated by the Executive Director of Health Services shall monitor the "Tracking Log" to ensure tests have been completed per the physician order. 3. When results are received it shall be so noted on the "Tracking Log" with the physician notified of the results in accordance with the Notification Guidelines...." 4.) Review of the current facility policy, effective 12/6/2007, provided by the DoN on 11/4/13 at 9:20 a.m.,			

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	titled "Physician Notification Guidelines", included, but were not limited to, the following: "Purpose: To ensure the resident's physician is aware of all diagnostic testing results or change in condition in a timely manner to evaluate condition for need of provision of appropriate interventions for care.... 7. Diagnostic test results require a response from the physician noting they have reviewed the test results. Test results out of normal range should note whether or not treatment is desired. 8. The physician may return his/her response to the facility by fax or phone. 9. If the facility has not had a response to abnormal test results or request for physician intervention within 12 hours or normal test results within 72 hours, the nurse on duty will call the physician to obtain further instructions. 10. Attempts to notify the physician and their response should be documented in the resident record...."			

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	This federal tag relates to Complaint IN00138691. 3.1-35(g)(2)			

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F000505 SS=D	483.75(j)(2)(ii) PROMPTLY NOTIFY PHYSICIAN OF LAB RESULTS The facility must promptly notify the attending physician of the findings. Based on record review and interview, the facility failed to ensure the resident's oncologist was notified of laboratory tests in accordance with his orders for 1 of 3 residents reviewed for notification of lab tests in a sample of 3. (Resident #B) Findings include: The clinical record for Resident #B was reviewed on 11/1/13 at 9:15 a.m. Diagnoses for the resident included, but were not limited to, Metastatic Adenocarcinoma of the lung, diabetes mellitus, and deep vein thrombosis of the left leg. A physicians order, dated 10/9/13, indicated Resident #B was to have a weekly BMP (basic metabolic profile) test to be started on 10/10/13 due to endometrial cancer. The order indicated (name of resident's oncologist) was to be notified of the results of the weekly test. The clinical record indicated the BMP test was completed as ordered on 10/10/13 and again on 10/17/13 as	F000505	F 505 Corrective actions accomplished for those residents found to be affected by the alleged deficient practice: Resident B has been discharged from the campus. Identification of other residents having the potential to be affected by the same alleged deficient practice and corrective actions taken: DHS or designee review all resident lab orders for past 30 days to ensure the nursing staff notified the correct MD of lab test results in accordance with his/her orders. Measures put in place and systemic changes made to ensure the alleged deficient practice does not recur: DHS or designee will re-educate the Nursing Team on the following campus guidelines: Physician Notification. How the corrective measures will be monitored to ensure the alleged deficient practice does not recur: The following audits for 5 residents per hallway will be conducted by the DHS or designee 3 times per week times 8 weeks, then monthly times 4 months to ensure compliance: resident lab orders to ensure the nursing staff notified the correct MD of lab test results in accordance with his/her orders. The results of the audit observations will be reported,	12/04/2013

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	ordered. The 10/17/13 BMP test indicated the resident's blood urea nitrogen test was elevated at 34 (normal reference range 9-27) and the resident's serum creatinine test was elevated at 2.06 (normal reference range 0.57-1.0). A fax transmission note, dated 10/17/13, on the lab test indicated that the test results had been faxed to the resident's primary physician (who ordered medication changes based on the test results) and not her oncologist as ordered. The clinical record lacked any info related to the resident's oncologist having been notified of the test results. During an interview on 11/1/13 at 1:40 p.m., the DoN indicated the nurse who had faxed the lab to the primary physician on 10/17/13, had not "stamped" the lab with all the necessary information that they were supposed to when the lab was faxed. She indicated she was unable to provide any information related to the oncologist having also been notified of the 10/17/13 lab test results. Review of the current facility policy, effective 12/6/2007, provided by the DoN on 11/4/13 at 9:20 a.m., titled		reviewed and trended for compliance thru the campus Quality Assurance Committee for a minimum of 6 months then randomly thereafter for further recommendation.	

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	"Physician Notification Guidelines", included, but was not limited to, the following: "Purpose: To ensure the resident's physician is aware of all diagnostic testing results or change in condition in a timely manner to evaluate condition for need of provision of appropriate interventions for care...." This federal tag relates to Complaint IN00138691. 3.1-49(f)(2)			