

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155272	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/28/2012
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NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB-CASTLETON	STREET ADDRESS, CITY, STATE, ZIP CODE 5226 E 82ND ST INDIANAPOLIS, IN 46250
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F0000	<p>This visit was for Investigation of Complaint IN00114897.</p> <p>Complaint IN00114897 Substantiated, Federal/State deficiencies related to the allegations are cited at F157, F225, F282, F329.</p> <p>Survey dates: August 27 & 28, 2012</p> <p>Facility number: 000172 Provider number: 155272 AIM number: 100267130</p> <p>Survey Team: Mary Jane G. Fischer RN</p> <p>Census bed type: SNF/NF: 110 Total: 110</p> <p>Census payor type: Medicare: 17 Medicaid: 81 Other: 12 Total: 110</p> <p>Sample: 3</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p>	F0000		
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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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	Quality review 8/31/12 by Suzanne Williams, RN			

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F0157 SS=D	<p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) 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 physician notification in that when a resident had specific orders related to therapeutic blood levels for anticoagulation therapy,</p>	F0157	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.	09/22/2012			

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	<p>the nursing staff failed to notify the physician for possible intervention for 1 of 3 sampled residents. [Resident "A"].</p> <p>Findings include:</p> <p>The record for Resident "A" was reviewed on 08-27-12 at 1:10 p.m. Diagnoses included, but were not limited, to pernicious anemia, pressure ulcer, embolism, dementia, hypertension, chronic kidney disease, peripheral neuropathy and neuropathy. These diagnoses remained current at the time of the record review.</p> <p>Upon return to the facility from a local area hospital for wound therapy, a physician order dated 07-26-12 included the medications Warfarin [an anticoagulant] 6 mg [milligrams] daily.</p> <p>The resident had physician orders for routine PT/INR [Protime/International Normalized Ratio- a blood laboratory test for blood clotting] two times a week on Monday and Thursday.</p> <p>The resident's laboratory results dated 08-09-12 [Thursday] indicated the INR was 2.47.</p> <p>The physician order dated 08-10-12 instructed the nursing staff to decrease the</p>		<p>This plan of correction is prepared and/or executed solely because required.F 157 Notify of Changes (A)What corrective action(s) will be accomplished for those residents found to have been affected by the practice:Resident #A no longer resides in the facility (b)How you will identify other residents having potential to be affected by the same practice and what corrective action will be taken: A facility audit was conducted to identify current residents that receive Coumadin/and or PT/INR to determine if MD notification was completed with the results. Any identified issues resulted in immediate MD notification and disciplinary action/counseling to the responsible caregiver. (C) What measures will be put into place or what systematic changes you will make to ensure that the practice does not recur:Licensed nursing staff was educated regarding MD/Family notification with change of condition including INR results and the importance of monitoring for increased bleeding.The unit manager will monitor orders, INR results 5 days weekly to ensure accurate and timely documentation and notification when necessary have been made to help ensure continued compliance.Any identified issues will result disciplinary action/counseling to</p>				

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	<p>anticoagulant to 5 mg daily and "New goal for INR 1.5 - 2.0, Call if > [greater than] 2.0."</p> <p>The resident had blood work drawn on 08-13-12 [Monday] and the result of the INR was 2.58.</p> <p>The nurses notes lacked documentation the physician had been notified.</p> <p>A subsequent laboratory result dated 08-16-12 [Thursday] indicated the INR was 4.42.</p> <p>Review of the Medication Administration Record for August 2012 indicated the resident received the anticoagulant 08-13-12, 08-14-12, and 08-15-12.</p> <p>The facility policy reviewed on 08-28-12 at 10:10 a.m., provided by the Administrator, titled "Notifications," and dated 10-31-07 indicated the following:</p> <p>"Policy [bold type] Staff informs the resident, consults with their attending physician, and notifies the resident's surrogates when:</p> <ul style="list-style-type: none"> * A significant change occurs in the resident's physical, mental or psychosocial status; * Treatment needs to be altered significantly ..." 		<p>the responsible caregiver.(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: DNS/Designee will review INR results to identify any lab parameters as identified by MD 5 days weekly during morning clinical meeting, any identified issues will result in review of Residents clinical record to ensure documentation of MD/Family notification this will be an ongoing plan of correction.The ED will report results of audits at the next PI meeting and monthly for 3 months then will have quarterly monitoring by the DNS/Designee to maintain compliance. Date of compliance 9-22-12</p>				

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	<p>Interview on 08-28-12 at 11:50 a.m., the Director of Nurses verified the record lacked documentation the nursing staff notified the physician of the increase to the INR as directed.</p> <p>This Federal tag relates to Complaint IN00114897.</p> <p>3.1-5(a)(3)</p>				

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F0225 SS=D	<p>483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS</p> <p>The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>Based on record review and interview, the</p>	F0225	Preparation and/or execution of	09/22/2012			

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	<p>facility failed to ensure a complete and thorough investigation was conducted, in that when the facility was notified of a possible sexual assault, the facility failed to conduct a thorough investigation which included assessing other residents for physical signs of abuse, for 1 of 3 residents reviewed for allegations of abuse in the sample of 3. [Resident "A"].</p> <p>Findings include:</p> <p>The record for Resident "A" was reviewed on 08-27-12 at 1:10 p.m. Diagnoses included but were not limited to, pernicious anemia, pressure ulcer, embolism, dementia, hypertension, chronic kidney disease, peripheral neuropathy and neuropathy. These diagnoses remained current at the time of the record review.</p> <p>The resident had a change in condition and was transported to the local area hospital on 08-17-12.</p> <p>Review of the resident's progress notes, dated 08-17-12, documented by the Director of Nurses and indicated the following:</p> <p>"5:30 p.m. Writer received call from nurse at [name of local area hospital] to inform facility there is an allegation of</p>		<p>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 225 Notify of Changes (A)What corrective action(s) will be accomplished for those residents found to have been affected by the practice: Resident #A no longer resides in the facility(b)How you will identify other residents having potential to be affected by the same practice and what corrective action will be taken: Residents who are cognitively intact were interviewed to determine if any voiced concerns R/T abuse. Those residents that are considered "non-interviewable" were assessed for physical signs of abuse and Residents family was interviewed. No new issues were identified. (C) What measures will be put into place or what systematic changes you will make to ensure that the practice does not recur:Current staff was educated regarding Abuse with facility policy with special attention to reporting and thorough investigation.The Social Service Director will meet 2 times monthly for 3 months with the Resident Council to ensure concerns are brought to the Administrator for investigating, reporting, resolution, and</p>				

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	<p>sexual assault and reported resident has 'torn labia.' Writer asked nurse if resident was interviewed and nurse did not respond to question."</p> <p>Review of the local area hospital Emergency Room Report, dated 08-17-12 indicated the following "[Resident] resides in an ECF [extended care facility] presents here for vaginal bleeding or blood in the urine. Apparently was noted by the nursing staff to have some more vaginal bleeding today. Demonstrates there appears to be a superficial laceration involving the left labia measuring approximately 2 cm [centimeters]. Etiology for patient's vaginal laceration is unclear."</p> <p>Further review of the emergency room notations indicated the resident was assessed with an abrasion to the outside of the perineum at the beginning of labia and an ovoid tear the size of nail bed of thumb on the inside of the labia majora.</p> <p>The notation indicated the hospital Forensic Nurse was notified.</p> <p>Interview with the hospital forensic nurse on 08-27-12 at 8:45 a.m. indicated, "I could see an oval wound inside of the left labia, I couldn't get the measurement device on it, but it was about the size of</p>		<p>follow-up immediately if abuse is reported.The Facility Management Team will review all event reports, allegations and concerns daily during the Monday through Friday stand up meeting in order to investigate, resolve, report and follow-up with any concerns.</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 Director of Social Services/Designee will randomly interview 5 residents weekly for the next 4 weeks then monthly thereafter, to determine if residents/staff have voiced concerns of abuse for thorough investigation and notification to management of the facility. If any of these 5 resident's are "non-interviewable", then DNS/Designee will assess for physical signs of abuse and interview families any abuse reported or suspected will be reported to the ED immediately.Review of these audits will be reported at the monthly PI meeting for 3 months then monitored quarterly with System reviews to ensure compliance is maintained. Date of compliance: 9-22-12</p>		

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	<p>the nail bed of the thumb."</p> <p>Interview on 08-28-12 at 9:15 a.m., the Director of Nurses indicated the Forensic Nurse from the hospital called and said there was an allegation because [resident] had a labia tear. I called the Administrator, and [name of clinical consultant]. [Name of Administrator] called corporate and also called the hospital. We bagged up everything. We called everyone in and started interviews - the alert residents, staff, everyone. We also did Abuse Inservice education for everyone."</p> <p>When interviewed if other residents were assessed for physical signs of abuse, due to the allegation of the "tear," the Director of Nurses indicated assessments were not conducted of other residents.</p> <p>Review of facility policy on 08-27-12 at 12:30 p.m., provided by the Administrator, titled "Conducting an Investigation," and dated 06-30-06 indicated the following:</p> <p>Rationale: Federal regulation requires a center have evidence that all allegations of abuse, neglect, and exploitation/misappropriation, including injuries of unknown source, are thoroughly investigated."</p>				

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	<p>"The Investigation - 1. Specify the type of allegation that is being reported. b. Sexual abuse. 2. Document the details of the incident. 7. Document other residents identified with physical signs of abuse. 9. Interview staff members, visitors and/or residents who may have knowledge of alleged incident being investigated...."</p> <p>This Federal tag relates to Complaint IN00114897.</p> <p>3.1-28(a) 3.1-28(d)</p>				

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F0282 SS=D	<p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on record review and interview, the facility failed to ensure physician orders and resident plans of care were followed for 1 of 3 residents reviewed for anticoagulation therapy resulting in Resident ["A"] being transported to a local area hospital for evaluation and treatment of significantly bleeding. [Resident "A"].</p> <p>In addition the facility failed to ensure plans of care were followed related to skin assessments for 1 of 3 sampled residents reviewed with wounds and indwelling catheters. [Resident "A"].</p> <p>Findings include:</p> <p>The record for Resident "A" was reviewed on 08-27-12 at 1:10 p.m. Diagnoses included, but were not limited to, pernicious anemia, pressure ulcer, embolism, dementia, hypertension, chronic kidney disease, peripheral neuropathy and neuropathy. These diagnoses remained current at the time of the record review.</p> <p>Review of the resident's current plan of</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:</p> <p>Resident #A no longer resides in the facility(B) How you will identify other residents having potential to be affected by the same practice and what corrective action will be taken:Residents that receive Coumadin had the potential to be affected. DNS completed audit of current residents in the facility receiving anticoagulants any identified issue was corrected and MD was notified.Audit was completed by DNS/wound nurse to identify residents that did not receive scheduled skin checks any identified issues resulted in immediate skin check and disciplinary action/counseling to the responsible caregiver.(C) What measures will be put into place or what systematic changes</p>	09/22/2012			

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	<p>care dated 07-28-12 and updated on 08-09-12, indicated "Anticoagulation - Risk for abnormal bleeding due to anticoagulant therapy."</p> <p>Interventions to this plan of care included "PT/INR [Protime/International Normalized Ratio] as ordered, report to MD [Medical Doctor] as indicated. Monitor for cloudy dark urine or black tarry stool, abdominal or lower back pain, bleeding gums with teeth brushing, increased bruising or sever <sic> headache. Report abnormal side effects to MD. Medications as ordered."</p> <p>Physician orders dated 07-26-12 Warfarin [an anticoagulant] 6 mg [milligrams] daily and Aspirin Enteric Coated 81 mg daily.</p> <p>The resident had physician orders for routine PT/INR two times a week on Monday and Thursday.</p> <p>The resident's laboratory results dated 08-09-12 [Thursday] indicated the INR was 2.47.</p> <p>The physician order dated 08-10-12 instructed the nursing staff to decrease the anticoagulant to 5 mg daily and "New goal for INR 1.5 - 2.0, Call if > [greater than] 2.0."</p>		<p>you will make to ensure that the practice does not recur:Nursing staff was educated on the importance of completing skin checks weekly and the importance of notification and documentation of any identified areasNursing staff was educated on anticoagulation therapy and signs to monitor for increased bleeding.DNS/Designee will monitor skin checks 5 days weekly to ensure skin sheets completed and any needed notification was documented. (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 UM/designee will conduct a random weekly audit of at least 5 residents per week x 4 weeks then every 2 weeks for the next 2 months - to ensure that each resident's plan of care is being followed as ordered by their attending physician with a focus on skin assessments and notification of MD with any changes. The findings from these audits will be reviewed at the facility PI meeting monthly for 3 months, and then quarterly monitoring by facility PI when the DNS when completes the facility system reviews.Date of compliance: 9-22-12</p>				

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	<p>The resident had blood work drawn on 08-13-12 [Thursday] and the result of the INR was 2.58.</p> <p>The nurses notes lacked documentation the physician had been notified of the increase to the INR and review of the August 2012 Medication Administration Record indicated the resident continued to receive the anticoagulant on 08-13-12, 08-14-12 and 08-15-12.</p> <p>In addition the resident had a current plan of care dated 07-27-12 for "Alteration in skin integrity as evidenced by Stage 4 sacral wound and osteomyelitis."</p> <p>Interventions to this plan of care instructed the nursing staff to "Encourage /promote good hygiene - assist as needed, report any drainage to MD or increase s/s [signs and/or symptoms] of infection, monitor for circulatory problems - color and warmth of extremity, and weekly skin assessment."</p> <p>Review of "Resident Weekly Skin Check Sheet," for August 2012 instructed the nursing staff "Indicate below skin injuries/ulcers such as pressure ulcers, venous insufficiency/ischemia ulcers (i.e. [for example] venous stasis and arterial ischemic ulcers), diabetic neuropathic</p>			

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NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB-CASTLETON	STREET ADDRESS, CITY, STATE, ZIP CODE 5226 E 82ND ST INDIANAPOLIS, IN 46250
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	<p>ulcers, bruises, abrasions, lacerations and abnormal skin discoloration by marking the body. Comment on color, moisture, temperature, integrity and/or turgor as appropriate."</p> <p>The skin assessment sheet indicated the resident was assessed on 08-06-12 "Week 1" with an open area to coccyx. The "Week 2" assessment was blank.</p> <p>Review of the resident hospital record on 08-27-12 at 8:35 a.m., indicated the resident was transported to the local area hospital on 08-17-12 due to hematuria. Review of the emergency room notations indicated the resident was assessed with an abrasion to the outside of the perineum at the beginning of labia and an ovoid tear the size of nail bed of thumb on the inside of the labia majora.</p> <p>Interview with the hospital forensic nurse on 08-27-12 at 8:45 a.m. indicated, "I could see an oval wound inside of the left labia, I couldn't get the measurement device on it, but it was about the size of the nail bed of the thumb."</p> <p>Interview on 08-28-12 at 10:00 a.m. CNA [Certified Nurses Aide] employee #6 indicated the resident had a catheter and when she provided pericare to the resident she had to turn the resident to the side and</p>			

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	<p>"prop a pillow between [resident] legs" because the resident was "contracted." I had to wipe from behind." When interviewed if she was able to view the entire perineum when providing care the CNA indicated, "No, I just did the best I could."</p> <p>Interview on 08-28-12 at 9:15 a.m., the Director of Nurses verified the skin sheet lacked documentation by the nursing staff. [Name of Licensed Practical Nurse employee #8] should have completed it [in reference to the weekly skin assessment]."</p> <p>This Federal tag relates to Complaint IN00114897.</p> <p>3.1-35(g)(2)</p>				

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F0329 SS=G	<p>483.25(I) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS</p> <p>Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>Based on interview and record review, the facility failed to ensure the monitoring of laboratory results in conjunction with the use of an anticoagulation therapy for 1 of 3 residents reviewed for medications with laboratory monitoring, physician notification and intervention.</p> <p>This deficient practice resulted in profuse bleeding and the resident transported to a local area hospital for intervention to reverse the effects of the anticoagulant. [Resident "A"].</p>	F0329	<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 329 Unnecessary medications (A)What corrective action(s) will be accomplished for those residents found to have been affected by the practice:Resident #A no longer resides in the facility(b)How you</p>	09/22/2012	

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	<p>Findings include:</p> <p>The record for Resident "A" was reviewed on 08-27-12 at 1:10 p.m. Diagnoses included, but were not limited to, pernicious anemia, pressure ulcer, embolism, dementia, hypertension, chronic kidney disease, peripheral neuropathy and neuropathy. These diagnoses remained current at the time of the record review.</p> <p>Review of the resident's current plan of care dated 07-28-12 and updated on 08-09-12, indicated "Anticoagulation - Risk for abnormal bleeding due to anticoagulant therapy."</p> <p>Interventions to this plan of care included "PT/INR [Protime/International Normalized Ratio] as ordered, report to MD [Medical Doctor] as indicated. Monitor for cloudy dark urine or black tarry stool, abdominal or lower back pain, bleeding gums with teeth brushing, increased bruising or sever <sic> headache. Report abnormal side effects to MD. Medications as ordered."</p> <p>The resident returned to the facility after a hospitalization at a local area hospital for wound therapy. Upon return, the resident had physician orders dated 07-26-12, which included Warfarin [an</p>		<p>will identify other residents having potential to be affected by the same practice and what corrective action will be taken: A facility audit was conducted to identify current residents who receive Coumadin/and or PT/INR to determine if MD notification was completed with the results and current orders being followed. Any identified areas were reported to the MD. (C) What measures will be put into place or what systematic changes you will make to ensure that the practice does not recur: Licensed nursing staff was educated regarding MD/Family notification with change of condition including INR results. Licensed nursing staff was also educated on the components of F329 with special focus on Coumadin administration, following MD parameters, and monitoring for side effects.UM will monitor INR results/side effects as they are received to ensure MD notification and for any new orders if needed any issues identified will result in disciplinary action/counseling.</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:DNS/Designee will review INR results to identify any lab parameters as identified by MD 5 days weekly during morning</p>		

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	<p>anticoagulant] 6 mg [milligrams] daily.</p> <p>The resident had physician orders for routine PT/INR two times a week on Monday and Thursday.</p> <p>The resident's laboratory results dated 08-09-12 [Thursday] indicated the INR was 2.47.</p> <p>The physician order dated 08-10-12 instructed the nursing staff to decrease the anticoagulant to 5 mg daily and "New goal for INR 1.5 - 2.0, Call if > [greater than] 2.0."</p> <p>The resident had blood work drawn on 08-13-12 [Monday] and the result of the INR was 2.58.</p> <p>The nurses notes lacked documentation the physician had been notified.</p> <p>A subsequent laboratory result dated 08-16-12 [Thursday] indicated the resident's INR result was 4.42 [normal range .9 - 1.1].</p> <p>Review of the Medication Administration Record for August 2012 indicated the resident received the anticoagulant 08-13-12, 08-14-12, and 08-15-12.</p> <p>During interview on 08-28-12 at 9:50</p>		<p>clinical meeting, any identified issues will result in review of Residents clinical record to ensure documentation of MD/Family notification this will be an ongoing plan of correction. The ED will report results of audits at the next PI meeting and monthly for 3 months then will have quarterly monitoring by the DNS/Designee to maintain compliance. Date of compliance: 9-22-12</p>		

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	<p>a.m. the nurse practitioner indicated, "The aide came to get me [in reference to Friday 08-17-12]. We turned [resident] to the right side and I lifted [resident] bottom while the aide held [resident]. There was so much blood I couldn't see a thing. It [in reference to the bleeding] was coming from around the catheter. I couldn't even find where it was bleeding to apply pressure. [Resident] was sent out 911."</p> <p>During interview on 08-28-12 at 10:00 a.m., CNA employee #6 indicated "I noticed blood in the urine bag on Monday and as the week went on it got heavier and heavier. On that day, the first thing in the morning it was heavily red. Right before lunch I went to change [resident] and the pad was saturated [in reference to blood]. It looked like the bleeding was coming from around the catheter and there was blood on the leg strap - it was bloody as well. [Name of nurse practitioner] was sitting at the desk at the nurses station so I asked her to come and take a look."</p> <p>The ambulance report, dated 08-17-12, indicated "Urethral bleeding - anatomic location genitalia. Taken to [Name of local area hospital] for urethral bleed for unknown amount of time. Transported due to urethral bleed. Referring nurse</p>						

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	<p>didn't have a proximate onset of time when bleeding began. Nurse stated they did take [resident] foley catheter out earlier. Not actively bleeding during transport."</p> <p>Review of the Emergency Room Physician Report, dated 08-17-12, indicated "chief complaint - vaginal bleeding or blood in the urine. The INR is elevated at 5.37."</p> <p>Review of a hospital "Consultation" report, dated 08-17-12, indicated, "The patient was brought to the ER [Emergency Room] for gross hematuria which has been confirmed with catheter placement. The CT scan reveals a left internal double-J stent, which is in normal position and looks very similar to CT scan from 2008. Impression and Plan: Hematuria likely secondary to stent and urinary tract infection. The patient currently is on aspirin and Coumadin [an anticoagulant], which is exacerbating or hematuria. Current INR is 5.37."</p> <p>Review of the hospital "History and Physical," dated 08-17-12 indicated "Assessment" Supratherapeutic INR. We will hold Coumadin for right now. [Resident] is on Coumadin for what appears to be upper extremity deep venous thrombosis."</p>			

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	<p>The hospital Emergency Room Treatment Record, dated 08-17-12 indicated the resident received 5 mg of Vitamin K to reverse the effects of the anticoagulant.</p> <p>This Federal tag relates to Complaint IN00114897.</p> <p>3.1-48(a)(3)</p>			