

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155423	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/10/2014
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NAME OF PROVIDER OR SUPPLIER HAMMOND-WHITING CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1000 114TH ST WHITING, IN 46394
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F000000	<p>This visit was for the Investigation of Complaints IN00156060 and IN00157261. This visit resulted in a Partially Extended Survey-Immediate Jeopardy.</p> <p>Complaint IN00156060- Substantiated. Federal/State deficiencies related to the allegations are cited at F-225, F-226, and F-250.</p> <p>Complaint IN00157261- Unsubstantiated due to lack of evidence.</p> <p>Unrelated deficiencies are cited.</p> <p>Survey date: October 8, 2014 Extended survey dates: October 9 & 10, 2014</p> <p>Facility number: 000365 Provider number: 155423 AIM number: 100287460</p> <p>Survey team: Janet Adams, RN-TC (October 8 & 9, 2014) Janelyn Kulik, RN (October 10, 2014) Heather Hite, RN (October 10, 2014)</p>	F000000	<p>Kim Rhoades, Director of Long-Term CareIndiana State Department of Public Health2 North Meridian St.Indianapolis, IN 46204Dear Ms Rhoades:Please reference the enclosed 2567 as "Plan of Correction" for the October 10, 2014 Complaint Survey that was conducted at Hammond Whiting Care Center.Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth facts alleged or conclusion set forth in the statement of deficiencies. This plan of correction is prepared and/or executed solely because it is required by the provision of the Federal and State Laws. This facility appreciated the time and dedication of the Survey Team; the facility will accept the survey as a tool for our facility to use in continuing to better the quality of care provided to our Elders in our community.The Plan of Correction submitted on October 30, 2014 serves as our allegation of compliance. Should you have any question or concerns regarding the Plan of Correction, please contact me. Respectfully, Kimberly M. Ready, HFExecutive Director</p>	

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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F000225 SS=D	<p>Census bed type: SNF/NF: 66 Total: 66</p> <p>Census payer type: Medicare: 13 Medicaid: 44 Other: 9 Total: 66</p> <p>Sample: 9 Supplemental Sample: 3</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed on October 19, 2014, by Janelyn Kulik, RN.</p> <p>483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS 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</p>						

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	<p>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 facility failed to ensure staff reported an allegation of possible abuse to the Administrator and failed to ensure an investigation of the allegation was completed in a timely manner for 1 of 2 Abuse allegations reviewed. (Resident #D) (LPN #1) (CNA #1 and CNA #2)</p> <p>Findings include:</p>	F000225	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:As soon as administration was notified of allegation, head to toe assessment was completed by nursing staff for Resident #D on 8/19/2014 with no signs or symptoms of injury and/or emotional distress. Facility staff continued to monitor resident for 72-hours in addition to resident's call light placement with no further issues identified. <u>How</u>	11/05/2014			

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	<p>The facility Abuse investigations were reviewed on 10/8/14 at 12:00 p.m. An Incident Report Form indicated the Administrator was notified by Resident #D's daughter on Tuesday 8/19/14 about an incident the daughter stated had occurred on Saturday 8/16/14 when she was visiting Resident #D at the facility in the evening. The Incident indicated the daughter found the resident's call light behind his bed and the resident was hollering for staff. When the daughter questioned the resident about who did it the resident reported a physical description of the staff member and the staff member stated "I'm tired of everyone calling me."</p> <p>The facility Incident Form indicated the facility's immediate action included a head to toe assessment of the resident and no injury was noted. The facility spoke with staff members working the day in question and reviewed staffing schedules. No staff member meeting the physical description provided had been working on the day/shift the incident was alleged to have occurred was identified. Other Immediate interventions put into place were to monitor the resident's call light placement.</p> <p>When interviewed on 10/8/14 at 2:18 p.m., the Director of Nursing indicated</p>		<p><u>other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions(s) will be taken:</u> Abuse audit was performed by Social Services on 8/19/2014 of other alert and oriented residents located on same unit as Resident #D with no issues identified with care and/or staff member(s). <u>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</u> Licensed Nurse in charge of South Unit on the evening of 8/16/2014, date of alleged incident, was given verbal education by Director of Nursing on 8/19/2014 relating to facility abuse policy and reporting abuse allegation guidelines. In addition, a written verbal corrected action was given relating to facility abuse policy, reporting abuse allegation guidelines, and call light placement. Education relating to facility abuse policy was provided by the Staff Development Coordinator during all staff meeting on 9/25/2014. In addition, re-education relating to the facility abuse policy and reporting abuse allegation guidelines will be provided by the Staff Development Coordinator and/or designee to facility staff by November 9, 2014. <u>How the corrective action(s) will be monitored to ensure the deficient practice will not recur:</u> The facility</p>				

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	<p>CNA #1 was interviewed. The CNA stated Resident #D's daughter had stated someone took her fathers' call light and "threw" it behind the bed on 8/16/14.</p> <p>Continued interview with the Director of Nursing indicated LPN #1 was working on the Evening shift the allegation occurred. The Director of Nursing indicated during the interview with the LPN on 8/19/14, LPN #1 stated she was working on 8/16/14 and Resident #D's daughter had reported concerns with the call light and reported that someone threw the call light on the floor.</p> <p>Continued interview with the Director of Nursing indicated CNA #2 was working the Evening shift that the allegation occurred. The Director of Nursing indicated CNA #2 was interviewed and also stated the resident's daughter said someone threw the resident's call light behind the bed.</p> <p>When interviewed on 10/8/14 at 2:18 p.m., the facility Administrator indicated no staff had reported any allegations to her between 8/16/14 and 8/19/14. The Administrator indicated the event should have been reported to her on 8/16/14 as an allegation of possible abuse.</p> <p>The facility Abuse Policy titled</p>		<p>screens all potential employees with background checks and follows the Life Care Centers of America Policy and Procedure for Abuse Prevention and Abuse Reporting. In-services on abuse are provided at all staff meetings and quarterly and as needed to ensure staff are aware of the types of abuse and the importance of immediately following the facility policy for abuse including prompt reporting of any allegations of abuse. Facility Management to conduct staff interviews utilizing a specified questionnaire related to reporting alleged abuse. Three employees from various departments and on different shifts will be interviewed on a weekly basis for six months. All audit and questionnaire results and system components will be reviewed by the QA Committee with subsequent plans of correction developed and implemented as deemed necessary.</p>				

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F000226 SS=D	<p>"Protection of Residents: Reducing the Threat of Abuse and Neglect" was reviewed on 10/9/14 at 11:00 a.m. The policy indicated "all personnel were to promptly report any incident or suspected incident of resident abuse and/or neglect, including injuries of unknown origin." The policy also indicated the incident was to be reported to the Administrator or his designated representative and the Director of Nursing immediately. The policy also indicated the Administrator, Director of Nursing, or designated representative were to complete an investigation of the incident.</p> <p>This Federal tag relates to Complaint IN00156060.</p> <p>3.1-28(c) 3.1-28(d)</p> <p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. Based on record review and interview, the facility failed to follow their Abuse</p>	F000226	What corrective action(s) will be accomplished for those residents found to have been affected by	11/05/2014			

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	<p>Policy and procedures related to an allegation of possible abuse not reported to the Administrator which resulted in the Allegation not being investigated in a timely manner as per policy. (Resident #D), (LPN #1) (CNA #1 and CNA #2)</p> <p>Findings include:</p> <p>The facility Abuse investigations were reviewed on 10/8/14 at 12:00 p.m. An Incident Report Form indicated the Administrator was notified by Resident #D's daughter on Tuesday 8/19/14 about an incident the daughter stated had occurred on Saturday 8/16/14 when she was visiting Resident #D at the facility in the evening. The Incident indicated the daughter found the resident's call light behind his bed and the resident was hollering for staff. When the daughter questioned the resident about who did it the resident reported a physical description of the staff member and the staff member stated "I'm tired of everyone calling me."</p> <p>When interviewed on 10/8/14 at 2:18 p.m., the Director of Nursing indicated CNA#1 was interviewed. The CNA stated Resident #D's daughter had stated someone took her fathers' call light and "threw" it behind the bed on 8/16/14.</p>		<p>the deficient practice:As soon as administration was notified of allegation, head to toe assessment was completed by nursing staff for Resident #D on 8/19/2014 with no signs or symptoms of injury and/or emotional distress. Facility staff continued to monitor resident for 72-hours in addition to resident's call light placement with no further issues identified.<u>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions(s) will be taken:</u>Abuse audit was performed by Social Services on 8/19/2014 of other alert and oriented residents located on same unit as Resident #D with no issues identified with care and/or staff member(s).<u>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</u> Licensed Nurse in charge of South Unit on the evening of 8/16/2014, date of alleged incident, was given verbal education by Director of Nursing on 8/19/2014 relating to facility abuse policy and reporting abuse allegation guidelines. In addition, a written verbal corrected action was given relating to facility abuse policy, reporting abuse allegation guidelines, and call light placement.Education relating to facility abuse policy was provided by the Staff</p>				

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	<p>Continued interview with the Director of Nursing indicated LPN #1 was working on the Evening shift the allegation occurred. The Director of Nursing indicated during the interview with the LPN on 8/19/14, LPN #1 stated she was working on 8/16/14 and Resident #D's daughter had reported concerns with the call light and reported that someone threw the call light on the floor.</p> <p>Continued interview with the Director of Nursing indicated CNA #2 was working the Evening shift that the allegation occurred. The Director of Nursing indicated CNA #2 was interviewed and also stated the resident's daughter said someone threw the resident's call light behind the bed.</p> <p>When interviewed on 10/8/14 at 2:18 p.m., the facility Administrator indicated no staff had reported any allegations to her between 8/16/14 and 8/19/14. The Administrator indicated the event should have been reported to her on 8/16/14 as an allegation of possible abuse.</p> <p>The facility Abuse Policy titled "Protection of Residents: Reducing the Threat of Abuse and Neglect" was reviewed on 10/9/14 at 11:00 a.m. The policy indicated "all personnel were to promptly report any incident or suspected</p>		<p>Development Coordinator during all staff meeting on 9/25/2014. In addition, re-education relating to the facility abuse policy and reporting abuse allegation guidelines will be provided by the Staff Development Coordinator and/or designee to facility staff by November 9, 2014. <u>How the corrective action(s) will be monitored to ensure the deficient practice will not recur:</u> The facility screens all potential employees with background checks and follows the Life Care Centers of America Policy and Procedure for Abuse Prevention and Abuse Reporting. In-services on abuse are provided at all staff meetings and quarterly and as needed to ensure staff are aware of the types of abuse and the importance of immediately following the facility policy for abuse including prompt reporting of any allegations of abuse. Facility Management to conduct staff interviews utilizing a specified questionnaire related to reporting alleged abuse. Three employees from various departments and on different shifts will be interviewed on a weekly basis for six months. All audit and questionnaire results and system components will be reviewed by the QA Committee with subsequent plans of correction developed and implemented as deemed necessary.</p>				

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F000250 SS=D	<p>incident of resident abuse and/or neglect, including injuries of unknown origin." The policy also indicated the incident was to be reported to the Administrator or his designated representative and the Director of Nursing immediately. The policy also indicated the Administrator, Director of Nursing, or designated representative were to complete an investigation of the incident.</p> <p>This Federal tag relates to Complaint IN00156060.</p> <p>3.1-28(a)</p> <p>483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. Based on observation, record review, and interview, the facility failed to ensure medically-related social services were provided related to lack of addressing the Nurse Practitioner's recommendation for in-patient psychiatric services to be provided for 1 of 3 residents reviewed for psychotropic medication use in the</p>	F000250	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:Resident #D is currently being evaluated at a geriatric psychiatric facility in Chicago, IL. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective	11/05/2014

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	<p>sample of 9. (Resident #D)</p> <p>Findings include:</p> <p>On 10/8/14 at 10:55 a.m., Resident #D was observed sitting in a wheel chair in the Dining Room during an Activity with other residents in attendance. The resident was yelling out loudly repeatedly.</p> <p>On 10/8/14 at 1:45 p.m., the resident was observed in his room. The resident was yelling out random statements.</p> <p>The record for Resident #D was reviewed on 10/8/14 at 10:45 a.m. The resident's diagnoses included, but were not limited to, vascular dementia with delusions, anxiety, insomnia, organic brain syndrome with agitation, congestive heart failure, diabetes mellitus, and a history of a stroke and multiple myeloma. The resident was sent to the hospital on 9/2/14 and returned to the facility on 9/15/14.</p> <p>The 7/28/14 Minimum Data Set (MDS) assessment indicated the resident's BIMS (Brief Interview for Mental Status) score was (3). A score of (3) indicated the resident's cognitive patterns were severely impaired. The MDS also indicated the resident displayed behaviors</p>		<p>actions(s) will be taken:Psychiatric Nurse Practitioner notes and recommendations were reviewed from the previous days to ensure proper follow up was completed and documentation is present in the clinical record. No issues were identified via this audit.<u>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</u> Social Service Director was provided education regarding F250 regulatory guidelines per the facility's nurse consultant. Once psychiatric progress notes and recommendation are received Social Service Director and Nursing Administration will review and complete necessary follow up in a timely manner. <u>How the corrective action(s) will be monitored to ensure the deficient practice will not recur:</u>Social Service Director and Nursing Administration to perform a random weekly audit on five charts for next six months to ensure psychiatric progress notes, recommendations, and referrals are completed. Any issues identified will be immediately addressed and all audit results and system components will be reviewed monthly by the QA Committee with subsequent plans of correction developed and implemented as deemed necessary.</p>				

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	<p>daily.</p> <p>A care plan initiated on 8/25/14 indicated the resident displayed behaviors in groups. A care plan initiated on 9/27/14 indicated the resident was at risk for adverse reactions related to the use of psychotropic medications.</p> <p>The 9/2014 Physician orders were reviewed. An order written on 9/2/14 indicated the resident was to be sent to the hospital for a geriatric psychiatric evaluation.</p> <p>Review of the 9/2/14 hospital History and Physical indicated the resident was seen for dyspnea (difficulty breathing) and was disorientated to time and place. The History and Physical also indicated the resident had a history of vascular dementia.</p> <p>A 9/12/14 hospital Neurology Consult Note indicated the resident was admitted on 9/2/14 to the Emergency Room from a long term care facility for extreme agitation and confusion. The resident presented with a request from the long term care facility for the resident to receive a psychiatric evaluation.</p> <p>Review of the 9/15/14 re-admission Physician orders indicated orders were</p>				

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	<p>written for the resident to receive the following medications:</p> <p>Lorazepam (an anti-anxiety medication) 0.5 milligrams twice daily at 6:00 a.m. and 6:00 p.m.</p> <p>Memantine (a medication to treat dementia) 10 milligrams twice day at 8:00 a.m. and 8:00 p.m.</p> <p>Physician orders were written on 9/16/14 for the following medications changes:</p> <p>Risperdal (an anti-psychotic medication) 0.25 milligrams twice a day at 8;00 a.m. and 8:00 p.m.</p> <p>Ativan 1 milligram at hour of sleep for 14 days</p> <p>Lorazepam 0.5 milligrams to be discontinued</p> <p>The 10/2014 Psychiatric Progress Notes were reviewed. The 10/3/2014 progress note indicated the resident was seen by the Nurse Practitioner. The progress note indicated the resident had been sent to the hospital for a geriatric psychiatric evaluation on 9/2/14. The progress note indicated the resident was not medically cleared at the hospital and was not able to be seen in the psychiatric services unit during his hospitalization from 9/2/14-9/15/14.</p> <p>Continued review of the 10/3/14 Psychiatric Progress Note indicated the</p>			

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	<p>resident returned to the facility with the same behaviors he left with and continued to yell out and resist care. The progress note also indicated the resident was currently receiving anti anxiety medications and the Risperdal (anti-psychotic) medication was discontinued. New orders were given for Depakote to be initiated. The progress note also indicated the Nurse Practitioner recommended the "resident be evaluated in an inpatient psychiatric setting for and inpatient hospital stay." The Nurse Practitioner also noted it was in the best interest of the resident to be placed in an inpatient gero (geriatric) psychiatric unit for "evaluation, treatment, and stabilization of his condition."</p> <p>Review of the 10/3/14 thru 10/9/14 Nursing and Social Service Progress Notes indicated a Social Service Progress Note was entered on 10/8/14 at 8:11 a.m. The note indicated the resident had gone out to the Dentist on 10/7/14 and when he returned to the facility he continued to yell out very loudly. The resident was taken into the Social Service office as an intervention to see if he would quite down and he continued to yell out. The resident replied "no" when he was asked if anything was wrong and was offered some ice cream. The resident was quite for a minute and began to yell again. All</p>			

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	<p>interventions were unsuccessful.</p> <p>An entry made in the Nursing Progress Notes on 10/2/14 at 11:42 p.m. indicated the resident yelled out loudly the majority of the shift and did not seem concerned with other people around him. The entry also indicated the resident repeatedly asked to get out of bed when he was in bed and once was gotten up in the wheel chair he asked to go back to bed.</p> <p>A Behavior Meeting note entry was made on 10/2/14 at 10:27 a.m. This entry indicated the resident continued to holler out and his medications had been changed. The entry also indicated the Psychiatric Nurse followed the resident.</p> <p>Review of the 10/3/14 through 10/9/14 Nursing Progress Notes indicated an entry was made on 10/3/14 at 3:55 p.m. This entry indicated the resident was seen by the Psychiatric Nurse Practitioner and new medications and laboratory tests were ordered. There was no documentation related to recommendation for inpatient geriatric services. There was no documentation related to any arrangements made for the resident's need for geriatric in patient services between 10/3/14 and 10/9/14.</p>				

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	<p>The 10/2014 Behavior/ Intervention Monthly Flow Record was reviewed. The behavior being monitored was noted as "yelling out." The following daily entries were noted:</p> <p>10/1/14 Night shift: (5) episodes with outcome unchanged after interventions Day shift: (5) episodes with outcome unchanged after interventions Evening shift: (7) episodes with outcome worsened after interventions</p> <p>10/2/14: Day shift: (8) episodes with outcome worsened after interventions Evening shift: (7) episodes with outcome worsened after interventions Night shift: "all shift" recorded in place of number of behavior episodes with outcome unchanged after interventions</p> <p>10/31/4: Day shift: (8) episodes with outcome unchanged after interventions</p> <p>10/4/14 Evening shift: (7) episodes with outcome unchanged with interventions</p> <p>10/5/14 Evening shift: (7) episodes with outcome unchanged after interventions</p>				

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	<p>10/7/14 Night shift: (9) episodes with outcome worsened after interventions</p> <p>10/8/14 Night shift: (5) episodes with outcome worsened after interventions</p> <p>When interviewed during Orientation Tour on 10/8/14 at 8:20 a.m., the Director of Nursing indicated the resident was sent to hospital for psychiatric care and was not treated in the hospital psychiatric unit due to medical concerns noted.</p> <p>When interviewed on 10/9/14 at 8:45 a.m., the Social Service staff indicated she meets with the Psychiatric Nurse Practitioner when she arrives at the facility to see the residents and again when the Nurse Practitioner leaves the facility. The Social Service staff member indicated the last visit was 10/3/14. The Social Service staff member indicated she was aware of the 10/3/14 recommendation for Resident #D to be treated at an in-patient geriatric psychiatric facility. The Social Service staff member indicated the resident had been sent to the hospital for psychiatric services previously and was not admitted to the psychiatric unit as he did not pass medical clearance criteria. The Social</p>						

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	<p>Service staff member indicated she had previous discussions with Resident #D's family and they did not want him to go the psychiatric facility the Nurse Practitioner was at due to the facility being a longer distance for the family to travel to.</p> <p>Continued interview with the Social Service staff indicated she had spoken with the resident's attending Physician on the phone around 4:00 p.m. on 10/8/14. The Social Service staff member indicated she had not made any arrangements or discussions with family related to the 10/3/14 recommendation as she wanted to set up a meeting with the resident's family and Physician related to in patient treatment. The Social Service staff member indicated she had made no other attempts to arrange inpatient psychiatric care at this point as talking to the family related to psychiatric in patient treatment was "difficult" and they want to hear it from the Physician. The Social Service staff member also indicated when the resident was sent out for a psychiatric evaluation last month the family did not want places that were far away and she had not addressed this with the family related to the new recommendation made on 10/3/14.</p> <p>Further interview with the Social Service</p>						

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F000329 SS=J	<p>Staff on 10/9/14 at 8:52 a.m. indicated she had not attempted to call any other psychiatric facilities regarding in patient treatment for Resident #D since 10/3/14.</p> <p>When interviewed on 10/9/14 at 9:05 a.m., the Director of Nursing indicated she had not been aware of the 10/3/14 recommendation made by the Psychiatric Nurse Practitioner for the in patient treatment for Resident #D. The Director of Nursing indicated the facility should have started to address the recommendation on 10/3/14.</p> <p>This Federal tag relates to Complaint IN00156060.</p> <p>3.1-34(a)(3)</p> <p>483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS 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>			

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	<p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>Based on record review and interview, the facility failed to ensure the administration of an anticoagulant medication was discontinued as ordered by the Physician, to ensure Medication Administration Records and Physician Order Sheets were accurately carried over from month to month and accurately reflected the current Physician's orders, and failed to ensure a resident receiving an anticoagulant medication was monitored for potential adverse reactions or side effects and laboratory tests resulting in the resident needing multiple doses of Vitamin K after receiving anticoagulant medication for over two months after it was discontinued by the Physician and without any laboratory test of monitoring for excessive bleeding. This affected 1 of 4 residents reviewed for unnecessary medication in a sample of 9. (Resident #B)</p> <p>The Immediate Jeopardy began on July 1,</p>	F000329	<p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Resident received head to toe assessment by nursing on September 9, 2014 with no s/s of bleeding noted. Family and physician notified with orders received to discontinue Coumadin. PT/INR was immediately ordered and lab results communicated to physician with orders received to give resident 5mg of Vitamin K and repeat PT/INR the following day. Results from the follow up PT/INR was received and communicated to physician on 9/10/14 with orders received to repeat Vitamin K and perform PT/INR the following day. Results from the final PT/INR were received on 9/11/14 and reflected within normal limits. Data was relayed to physician with no new orders received. As of October 9, 2014 additional steps have been taken with resident B receiving another head to toe assessment, which identified 3 small faded</p>	11/05/2014

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	<p>2014 when the facility failed to ensure Physician's orders to discontinue an Anticoagulant medication were not removed from the Medication Administration Record resulting in the continued administration of the medication without a Physician's order and without ongoing monitoring of laboratory values and potential adverse reactions or side effects of the medication. The facility Administrator, Director of Nursing, and the Corporate Administrator were informed of the Immediate Jeopardy on 10/9/14 at 12:35 p.m. The Immediate Jeopardy was removed on October 10, 2014, but noncompliance remained at the lower scope and severity level of no actual harm with potential for more than minimal harm that is not Immediate Jeopardy.</p> <p>Findings include:</p> <p>The record for Resident #B was reviewed on 10/9/14 at 9:55 a.m. The resident's diagnoses included, but were not limited to, high blood pressure, anemia, stroke, end-stage renal disease, hemodialysis, and peripheral vascular disease.</p> <p>Review of the 9/11/14 Minimum Data Set (MDS) annual assessment indicated the residents' BIMS (Brief Interview for</p>		<p>bruises located on resident's upper right arm, which were initially noted on October 4, 2014. Resident states she receives insulin injections in this location. Resident's Physician Order Summary was checked to validate orders were accurate on Medication Administration Record. <u>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions(s) will be taken:</u> Full facility audit was completed by nursing administration related to physician orders and the monthly Physician Order Summary (POS). This audit served to as validation that all orders were properly communicated on the Medication Administration Record (MAR) and Treatment Administration Record (TAR). Any questions regarding orders were referred to the appropriate physician for clarification. On October 9, 2014, a full audit was conducted by nursing administration going back to July 1, 2014 through current date of October 9, 2014 to validate physician orders, Medication Administration Records, and flowsheets for accuracy. No issues were identified via this audit. Head to toe assessments were completed on October 9, 2014 of all residents on anti-coagulant medication with no signs or symptoms of bruising or bleeding. An addition full facility audit to</p>				

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	<p>Mental Status) score was (15). A score of (15) indicates the resident's cognitive patterns were intact. The MDS assessment also indicated the resident required extensive assistance (resident involved in activity, staff provide weight-bearing support) of two or more staff members for transfers and bed mobility. The assessment also indicated the resident required extensive assistance of one staff member for dressing and personal hygiene.</p> <p>Review of the 5/2014 Physician orders indicated there was an order written on 5/12/14 to discontinue Coumadin 10 milligrams daily . The Coumadin was originally ordered on 4/21/14 to be given for DVT(Deep Vein Thrombosis) prophylaxis. There was also an order to discontinue weekly PT/INR(laboratory tests to monitor clotting times) laboratory tests. The 5/2014 Medication Administration Record indicated the Coumadin was not given after 5/12/2014.</p> <p>The Nursing 2014 Drug Handbook was reviewed. The Handbook indicated Coumadin was an anticoagulant medication. The Handbook indicated the recommend INR range was usually 2-3. Nursing considerations included regular monitoring of INR levels in all patients. The Handbook also indicated elderly</p>		<p>validate current physician orders match each resident's medication in the medication carts was conduct by pharmacy on October 20, 2014, issues identified via this audit were immediately addressed and resolved. <u>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</u> Re-education was completed by the DON and/or designee to licensed nurses on September 19, 2014 in regards to physician orders and physician order processing procedure related to monthly recaps as per facility policy. On October 9, 2014 education provided by DON and/or designee to licensed nurses in regards to physician orders and physician order processing procedure related to monthly recaps, anti-coagulant policy and procedure, and identifying the residents at risk for inappropriate utilization policy. Education continues and will be provided to all nurses prior to working their next scheduled shift. Those nurses hired after the original in service will be educated during initial orientation, as these have been added as part of licensed personnel orientation. In-service roster was compared to facility staffing roster on October 29, 2014 and all licensed nurses education was completed. <u>How the corrective action(s) will be monitored to</u></p>	

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	<p>patients taking anticoagulants had an increased risk of bleeding and INR levels were to be monitored carefully.</p> <p>The 6/2014 Physician Order Sheet was reviewed. The Physician's order for Coumadin 10 milligram once a day appeared on the sheet. The date of 4/21/14 was written in the Order Sheet as the original start date of the Coumadin. There was a hand written line crossed through the Coumadin order with "DC/D" (discontinued) and the date of "5-12-14" both written by line through the Coumadin order. The Registered Pharmacist signed the Physician Order Sheet noting the resident's medications had been reviewed.</p> <p>The 7/2014 Physician Order Sheet was reviewed. The Physician's order for Coumadin 10 milligrams once a day appeared on the sheet. The date of 4/21/14 was written on the Order Sheet as the original start date of the Coumadin. The Order Sheet indicated the Coumadin was ordered for DVT (Deep Vein Thrombosis) prophylaxis(prevention). The Registered Pharmacist signed the Physician Order Sheet noting the resident's medications had been reviewed.</p> <p>The 8/2014 Physician Order Sheet was</p>		<p><u>ensure the deficient practice will not recur.</u>Nursing Administration to perform a weekly random audit on 5 charts for the next 6 months to ensure physician orders are properly communicated to the Medication Administration Record or Treatment Administration Record along with the resident's plan of care and/or care directives as needed. In addition, Nursing Administration will conduct a monthly random audit on 10 charts for the next 6 months to ensure the physician order processing procedure related to monthly recaps is followed as per facility policy. The facility has implemented a weekly audit performed by the DON and/or designee to ensure only those residents with a physician order for anti-coagulants are receiving the medication. This audit will be ongoing.Any issues identified will be immediately addressed and all audit results and system components will be reviewed monthly by the QA Committee with subsequent plans of correction developed and implemented as deemed necessary.</p>				

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	<p>reviewed. The Physician's order for Coumadin 10 milligrams once a day appeared on the sheet. The date of 4/21/14 was written on the Order Sheet as the original start date of the Coumadin. The Registered Pharmacist signed the Physician Order Sheet noting the resident's medications had been reviewed.</p> <p>The 9/2014 Physician Order Sheet was reviewed. The Physician's order for Coumadin 10 milligrams once a day appeared on the sheet. The date of 4/21/14 was written on the Order Sheet as the original start date of the Coumadin. The Registered Pharmacist signed the Physician Order Sheet noting the resident's medications had been reviewed.</p> <p>The 6/2014 Medication Administration Records were reviewed. The Coumadin 10 milligrams did not appear on the Medication Administration Record.</p> <p>The 7/2014 Medication Administration Records were reviewed. The facility was unable to locate the page of the July Medication Record listing the Coumadin. There were no "Coumadin Side Effect Flow/Sheet Anti-Coagulant Therapy Signs and Symptoms" sheets completed in July. There were no</p>						

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	<p>PT/INR/Coumadin Flow Sheet" forms completed in July 2014</p> <p>The 8/2014 Medication Administration Records were reviewed. Coumadin 10 milligrams was signed out as given daily at 5:00 p.m. There were no "Coumadin Side Effect Flow/Sheet Anti-Coagulant Therapy Signs and Symptoms" sheets completed in August. There were no PT/INR/Coumadin Flow Sheet" forms completed in August 2014.</p> <p>The 9/2014 Medication Administration Record indicated Coumadin 10 milligrams was last given on 9/8/14. There were no "Coumadin Side Effect Flow/Sheet Anti-Coagulant Therapy Signs and Symptoms" sheets completed in September. There were no PT/INR/Coumadin Flow Sheet" forms completed in September 2014.</p> <p>Review of the 5/2014 Laboratory test results indicated a PT/INR (a blood test to monitor the clotting time of the blood) was completed on 5/12/14. The PT level was 15.4 and the INR level was 1.5. The results page indicated the resident was on Coumadin and the Physician had been notified on 5/12/14 at 3:30 p.m. and new orders were noted.</p> <p>Review of the 9/2014 Laboratory results</p>						

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	<p>indicated a PT/INR test was completed on 9/9/14 at 2:48 p.m. The PT level was > 120.0. This result was identified as a critical level. The INR level was 9.7. This result was identified as a critical level. The Physician was notified and orders were received for resident to receive Vitamin K (a medication to treat elevated PT/INR levels) 5 milligrams and to repeat another PT/INR level on 9/10/14.</p> <p>The results of the 9/10/14 PT/INR test indicated the PT level was 83.4 and the INR level was 6.9. Both of the levels were identified as critical levels. The Physician was notified of the results and orders were received for the resident to receive Vitamin K 5 milligrams on 9/10/14 and for a PT/INR level to be drawn on 9/11/14.</p> <p>The results of the 9/11/14 PT/INR test indicated the PT level was 14.7 and the INR level was 1.4. These results were not noted as high or critical. The Physician was notified and no new orders were received.</p> <p>The 9/2014 Resident Progress Notes completed by Nursing staff were reviewed. An entry made on 9/2/14 at 2:20 p.m. indicated the resident was being</p>						

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	<p>monitored for bleeding to the fistula and upon arrival the resident was noted with a pressure dressing to the left arm. No active bleeding was noted and the resident denied pain or discomfort.</p> <p>An entry made on 9/2/14 at 9:20 p.m., indicated the resident was being monitored for a pressure dressing noted to the left arm fistula. No active bleeding was noted and the resident had no complaints of pain or discomfort</p> <p>An entry made on 9/3/14 at 4:05 p.m., indicated monitoring continued for the pressure dressing to the left arm fistula site. The dressing was removed this shift and no active bleeding was observed. A Band-aid was applied.</p> <p>An entry made on 9/9/14 at 2:17 p.m. indicated a Stat PT/INR was drawn today due to bleeding at dialysis.</p> <p>The 9/9/14 "Pre/Post Dialysis Communication" facility form was reviewed. The Pre-Dialysis section was completed at 4:45 a.m. No bleeding was noted to the access/site. The Dialysis Center section was completed by the Dialysis Center Nursing staff at 6:11 a.m. This entry indicated redness was noted to the access/site. No bleeding was noted. The Post Dialysis section was completed</p>				

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	<p>by the facility staff. The section noted bleeding. This entry was not signed or dated.</p> <p>Review of the 9/2/14 "Post Treatment" form completed at the Dialysis Center indicated the Bleeding Stop time was 10. The 9/9/14 "Post Treatment" form completed at the Dialysis Center indicated the Bleeding Stop time was 15.</p> <p>A "PT/INR/Coumadin Flow Sheet" form was reviewed. The form indicated the INR ranges for DVT (Deep Vein Thrombosis) treatment was 2.0-3.0. The form also indicated staff were to document the date/time of PT/INR levels, results of the PT/INR, the current dose of Coumadin, Physician notification, dose change, and date next PT/INR was to be completed.</p> <p>A "Coumadin Side Effect Flow/Sheet Anti-Coagulant Therapy Signs and Symptoms" form was reviewed. The form indicated staff were to document "Y" (yes) or "N" (no) to the following every shift: Unusual bleeding, any noted bruising, rapid heart rate, abdominal tenderness, nausea, vomiting, bleeding of the gums, or none noted.</p> <p>A Mandatory Nursing Meeting was held</p>						

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	<p>on 9/22/14. The inservice record indicated staff were educated related to the following:</p> <ul style="list-style-type: none"> -All residents on medications which put them at risk for bleeding were to have an Anticoagulant Flow Sheet in their Medication Record by Nursing staff. -Any resident receiving Coumadin must have a PT/INR weekly. Evening shift Nurses were responsible for this as they were the ones administering the medication. -When a resident is placed on an antibiotic, the Nurse who obtains the antibiotic order was responsible for getting PT/INR lab tests done three times a week. <p>When interviewed on 10/10/14 at 10:53 a.m., the ADON (Assistant Director of Nursing) indicated she had spoken to staff at the Dialysis Center and they informed her there were never any issues with the residents bleeding times noted above. The ADON also indicated the Dialysis staff informed her the resident's bleeding times were considered normal. The ADON also indicated the Dialysis staff also indicated if bleeding was present after dialysis they kept the resident until the bleeding was controlled and it is possible the ambulance staff could have told the facility the resident had bleeding when they returned her to</p>						

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	<p>the facility.</p> <p>When interviewed on 10/9/14 at 10:12 a.m., the Director of Nursing indicated a medication error for Resident #B was first noted on 9/9/14. The Director of Nursing indicated a Care Plan meeting was held for the resident on 9/9/14 and at the meeting staff reviewed the resident's current medications. They noted the 9/2014 Physician Order Statement indicated the resident was receiving Coumadin and upon further review it was determined the Coumadin had been discontinued in May 2014 per a Physician's order.</p> <p>The Director of Nursing indicated she spoke with Pharmacy the day the Medication Error was noted and was informed Pharmacy did not have a copy of the 5/12/14 or any of the June 2014 Physician Order Statements which would have identified the Coumadin had been discontinued on 5/12/14. The Director of Nursing also indicated she and the ADON began doing (10) audits a month of the monthly Physician Order Sheets and RN #2 was trained by watching audits as she was going to be the Nurse to check the Monthly Physician orders for all charts.</p> <p>The Director of Nursing indicated RN #1</p>						

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	<p>had been responsible for checking each months Physician Order Sheet for discrepancies or errors. The RN had noted the June Physician order Statement noted the Coumadin order still appeared. RN #1 crossed out the order on the Physician Order Statement and the June MAR (Medication Administration Record) and wrote discontinued.</p> <p>The Director of Nursing indicated the Physician order for Coumadin 10 milligrams daily appeared on the 7/2014 and the 8/2014 Physician Order Statements and the Medication Administration Records. The Director of Nursing indicated the Coumadin 10 milligrams was given daily thru July 2014 and August 2014.</p> <p>The Director of Nursing indicated the Physician order for Coumadin 10 milligrams daily appeared on the 9/2014 Physician Order Statement and the 9/2014 Medication Administration Record. The Coumadin was discontinued on 9/9/14.</p> <p>The Director of Nursing indicated the Physician was notified at the time the medication error was discovered and orders were received. A head to toe assessment of the resident was completed and PT/INR laboratory tests were</p>				

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	<p>ordered.</p> <p>The Director of Nursing indicated 9/10/14 thru 9/12/14 Management staff reviewed every Physician Order Statement sheets for all the residents, not just those on Coumadin. No other Coumadin errors were found. The Director of Nursing also indicated on 9/15/14 they also went over Physician orders for all residents receiving Coumadin with Pharmacy. The Director of Nursing indicated a Mandatory inservice was held on 9/22/14 for all the Nurses.</p> <p>The Director of Nursing indicated on 9/15/14 they reviewed with Pharmacy the orders for each resident receiving Coumadin to verify they had not received any orders for the Coumadin to be discontinued.</p> <p>The Director of Nursing indicated PT/INR and Side effects for Anticoagulants flow sheets were not completed in July 2014 and August 2014. The Director indicated the above should have been done during all days Resident #B received Coumadin doses. The Director of Nursing indicated there were Physician orders for the weekly PT/INR levels to be drawn when the resident had been receiving Coumadin 10 milligrams</p>						

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	<p>daily and these orders were discontinued on 5/12/14 when the Coumadin was discontinued.</p> <p>The Director of Nursing also indicated she herself trained RN #2 to do the monthly Physician Order Statements after the error was made by RN#1 which resulted in the resident receiving the Coumadin in July, August and September 2014.</p> <p>The Director of Nursing indicated after the Medication Error was identified the facility started looking at lab results on Mondays, Tuesdays and Thursdays. The Director of Nursing indicated routine labs are drawn on Mondays, Wednesdays, and Friday and meeting on the above day would capture tests done on the scheduled days. The Director of Nursing also indicated a system was put into place for the Evening Shift Nurse to verify each night that all the Coumadin flow documents were completed.</p> <p>The facility policy titled "Coumadin" was reviewed on 10/10/14 at 10:12 a.m. The policy indicated residents receiving Coumadin were to be monitored for side effects and receive Prothrombin (PT) studies and International Normalization Ratio (INR) studies regularly to determine the therapeutic dose. The</p>						

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	<p>policy indicated an INR above(4) had been "associated with a higher risk of bleeding without an increase in therapeutic benefit." For INR results of (4) or greater, the medication was to be held and the Physician was to be notified. The policy also indicated when an order for Coumadin was received or the dose of Coumadin is changed, Nursing staff are to note the order and notify the Pharmacy. The MAR (Medication Administration Record) should noted the discontinued dose and then enter the new Coumadin dose on MAR. The policy also indicated the MAR and the "PT/INR Coumadin Flow Sheet" are to be initiated or updated.</p> <p>The Immediate Jeopardy that began on July 1, 2014 was removed on October 10, 2014 when the facility completed clinical audits for the current residents medication orders to ensure the medications were given as ordered and the required monitoring was being completed. The facility also completed inservicing to Licensed Nurses related to noting of Physician orders and the procedures to be followed for new orders including medication changes and monitoring of effects of the medications the residents were receiving. The facility Administrator verified effective 9/10/14 a new staff assumed the position for</p>						

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F000428 SS=D	<p>completing all monthly Physician order recaps with Nursing Administration managing the process with continued oversight by randomly auditing to ensure the Physician ordering process was followed. The survey team completed chart reviews related to unnecessary medications. Nursing staff interviews were completed to ensure staff knowledge of the identified plan outlined by the facility related to the Immediate Jeopardy citation and audits were reviewed. The noncompliance remained at the lower scope and severity of no actual harm with potential for more than minimal harm that is not Immediate Jeopardy because the facility remained out of compliance at the lower level due to the need of further monitoring and audits to be completed.</p> <p>3.1-48(a)(3) 3.1-48(b)(2)</p> <p>483.60(c) DRUG REGIMEN REVIEW, REPORT</p>						

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	<p>IRREGULAR, ACT ON</p> <p>The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.</p> <p>The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.</p> <p>Based on record review and interview, the facility failed to ensure the Pharmacist reported irregularities related to the continued use of Coumadin (a blood thinner) for 1 of 4 residents reviewed for unnecessary medication use in the sample of 9. (Resident #B)</p> <p>Findings include:</p> <p>The record for Resident #B was reviewed on 10/9/14 at 9:55 a.m. The resident's diagnoses included, but were not limited to, high blood pressure, anemia, stroke, end-stage renal disease, hemodialysis, and peripheral vascular disease.</p> <p>Review of the 5/2014 Physician orders indicated there was an order written on 5/12/14 to discontinue Coumadin 10 milligrams daily . The Coumadin was originally ordered on 4/21/14 to be given for DVT(Deep Vein Thrombosis) prophylaxis. There was also an order to discontinue weekly PT/INR(laboratory tests to monitor clotting times) laboratory tests. The 5/2014 Medication</p>	F000428	<p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:Resident received head to toe assessment by nursing on September 9, 2014 with no s/s of bleeding noted. Family and physician notified with orders received to discontinue Coumadin. PT/INR was immediately ordered and lab results communicated to physician with orders received to give resident 5mg of Vitamin K and repeat PT/INR the following day. Results from the follow up PT/INR was received and communicated to physician on 9/10/14 with orders received to repeat Vitamin K and perform PT/INR the following day. Results from the final PT/INR were received on 9/11/14 and reflected within normal limits. Data was relayed to physician with no new orders received. As of October 9, 2014 additional steps have been taken with resident B receiving another head to toe assessment, which identified 3 small faded bruises located on resident's upper right arm, which were initially noted on October 4, 2014.</p>	11/05/2014			

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	<p>Administration Record indicated the Coumadin was not given after 5/12/2014.</p> <p>Review of the 5/2014 Laboratory test results indicated a PT/INR (a blood test to monitor the clotting time of the blood) was completed on 5/12/14. The PT level was 15.4 and the INR level was 1.5. The results page indicated the resident was on Coumadin and the Physician had been notified on 5/12/14 at 3:30 p.m. and new orders were noted.</p> <p>The 6/2014 Physician Order Sheet was reviewed. The Physician's order for Coumadin 10 milligram once a day appeared on the sheet. The date of 4/21/14 was written in the Order Sheet as the original start date of the Coumadin. There was a hand written line crossed through the Coumadin order with "DC/D" (discontinued) and the date of "5-12-14" both written by line through the Coumadin order. The Registered Pharmacist signed the Physician Order Sheet noting the resident's medications had been reviewed.</p> <p>The 7/2014 Physician Order Sheet was reviewed. The Physician's order for Coumadin 10 milligrams once a day appeared on the sheet. The date of 4/21/14 was written on the Order Sheet as the original start date of the Coumadin.</p>		<p>Resident states she receives insulin injections in this location. Resident's Physician Order Summary was checked to validate orders were accurate on Medication Administration Record. <u>How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions(s) will be taken:</u> Full facility audit was completed by nursing administration related to physician orders and the monthly Physician Order Summary (POS). This audit served to as validation that all orders were properly communicated on the Medication Administration Record (MAR) and Treatment Administration Record (TAR). Any questions regarding orders were referred to the appropriate physician for clarification. On October 9, 2014, a full audit was conducted by nursing administration going back to July 1, 2014 through current date of October 9, 2014 to validate physician orders, Medication Administration Records, and flowsheets for accuracy. No issues were identified via this audit. Head to toe assessments were completed on October 9, 2014 of all residents on anti-coagulant medication with no signs or symptoms of bruising or bleeding. An addition full facility audit to validate current physician orders match each resident's medication in the medication carts was</p>				

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	<p>The Order Sheet indicated the Coumadin was ordered for DVT Deep Vein Thrombosis) prophylaxis(prevention). The Registered Pharmacist signed the Physician Order Sheet noting the resident's medications had been reviewed.</p> <p>The 8/2014 Physician Order Sheet was reviewed. The Physician's order for Coumadin 10 milligrams once a day appeared on the sheet. The date of 4/21/14 was written on the Order Sheet as the original start date of the Coumadin. The Registered Pharmacist signed the Physician Order Sheet noting the resident's medications had been reviewed.</p> <p>The 9/2014 Physician Order Sheet was reviewed. The Physician's order for Coumadin 10 milligrams once a day appeared on the sheet. The date of 4/21/14 was written on the Order Sheet as the original start date of the Coumadin. The Registered Pharmacist signed the Physician Order Sheet noting the resident's medications had been reviewed.</p> <p>The 7/2014 Medication Administration Records were reviewed. The facility was unable to locate the page of the July Medication Record listing the Coumadin.</p>		<p>conduct by pharmacy on October 20, 2014, issues identified via this audit were immediately addressed and resolved. <u>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</u> Re-education was completed by the DON and/or designee to licensed nurses on September 19, 2014 in regards to physician orders and physician order processing procedure related to monthly recaps as per facility policy. On October 9, 2014 education provided by DON and/or designee to licensed nurses in regards to physician orders and physician order processing procedure related to monthly recaps, anti-coagulant policy and procedure, and identifying the residents at risk for inappropriate utilization policy. Education continues and will be provided to all nurses prior to working their next scheduled shift. Those nurses hired after the original in service will be educated during initial orientation, as these have been added as part of licensed personnel orientation. In-service roster was compared to facility staffing roster on October 29, 2014 and all licensed nurses education was completed. The 2567 was communicated to pharmacy in regards to F428 tag. Pharmacy provided education to facility's consultant pharmacist relating to</p>		

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	<p>There were no "Coumadin Side Effect Flow/Sheet Anti-Coagulant Therapy Signs and Symptoms" sheets completed in July. There were no PT/INR/Coumadin Flow Sheet" forms completed in July 2014</p> <p>The 8/2014 Medication Administration Records were reviewed. Coumadin 10 milligrams was signed out as given daily at 5:00 p.m. There were no "Coumadin Side Effect Flow/Sheet Anti-Coagulant Therapy Signs and Symptoms" sheets completed in August. There were no PT/INR/Coumadin Flow Sheet" forms completed in August 2014.</p> <p>The 9/2014 Medication Administration Record indicated Coumadin 10 milligrams was last given on 9/8/14. There were no "Coumadin Side Effect Flow/Sheet Anti-Coagulant Therapy Signs and Symptoms" sheets completed in September. There were no PT/INR/Coumadin Flow Sheet" forms completed in September 2014.</p> <p>Review of the 6/2014, 7/2104, and 8/2014 Laboratory test result reports indicated no PT/INR (blood test to check for blood thinning levels) laboratory tests had been completed.</p> <p>Review of the 9/2014 Laboratory results</p>		<p>pharmacy's policy and procedures for the consulting role and facility visit expectations. In addition, education was provided by pharmacy to the consultant pharmacist with regard to medication regimen review process. <u>How the corrective action(s) will be monitored to ensure the deficient practice will not recur:</u>An alternate pharmacist will complete a random review on ten charts monthly for the next six months of pharmacy consultants' completed monthly Medication Regimen Review to ensure irregularities related to unnecessary medications are noted and communicated to facility staff. Any issues identified will be immediately addressed and all audit results and system components will be reviewed monthly by the QA Committee with subsequent plans of correction developed and implemented as deemed necessary.</p>				

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	<p>indicated a PT/INR test was completed on 9/9/14 at 2:48 p.m. The PT level was > 120.0. This result was identified as a critical level. The INR level was 9.7. This result was identified as a critical level. The Physician was notified and orders were received for the resident to receive Vitamin K (a medication to treat elevated PT/INR levels) 5 milligrams and to repeat another PT/INR level on 9/10/14.</p> <p>The results of the 9/10/14 PT/INR test indicated the PT level was 83.4 and the INR level was 6.9. Both of the levels were identified as critical levels. The Physician was notified of the results and orders were received for the resident to receive Vitamin K 5 milligrams on 9/10/14 and for a PT/INR level to be drawn on 9/11/14.</p> <p>The results of the 9/11/14 PT/INR test indicated the PT level was 14.7 and the INR level was 1.4. These results were not noted as high or critical. The Physician was notified and no new orders were received.</p> <p>When interviewed on 10/9/14 at 10:12 a.m., the Director of Nursing indicated a medication error for Resident #B was first noted on 9/9/14. The Director of Nursing indicated a Care Plan meeting</p>						

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	<p>was held for the resident on 9/9/14 and at the meeting staff reviewed the resident's current medications. They noted the 9/2014 Physician Order Statement indicated the resident was receiving Coumadin and upon further review it was determined the Coumadin had been discontinued in May per a Physician's order and the PT/INR lab tests were also discontinued on 5/12/14 also.</p> <p>The Director of Nursing indicated she spoke with Pharmacy the day the Medication Error was noted and was informed Pharmacy did not have a copy of the 5/12/14 or any of the June 2014 Physician Order Statements which would have identified the Coumadin had been discontinued on 5/12/14.</p> <p>When interviewed on 10/9/14 at 12:00 p.m., the Director of Nursing indicated the resident's medication regime had been reviewed by the Pharmacist in August 2014 and no recommendations were made related to Coumadin.</p> <p>The facility policy titled "Nursing Home Pharmacy Practice" was reviewed on 10/10/14 at 2:49 p.m. The policy was received from the facility Administrator. The policy indicated "The nursing home pharmacy has two distinctly different roles:" The first role was the distribution</p>			

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NAME OF PROVIDER OR SUPPLIER HAMMOND-WHITING CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1000 114TH ST WHITING, IN 46394		
(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>of drugs. The second role was the information role of consulting. The policy indicated information-based services were the function of the consultant Pharmacist and services provided in this area included drug regime reviews, therapeutic drug monitoring, and monitoring for potential drug interactions, amongst other.</p> <p>3.1-25(i)</p>				