

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155459	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/04/2013
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NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT NEW CASTLE	STREET ADDRESS, CITY, STATE, ZIP CODE 901 N 16TH ST NEW CASTLE, IN 47362
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F0000	<p>This visit was for a Post Survey Revisit (PSR) to the Investigation of Complaint IN00119976 completed on 12/4/12.</p> <p>Survey date: January 4, 2013</p> <p>Facility number: 000341 Provider number: 155459 AIM number: 100286550</p> <p>Survey team: Sharon Lasher RN, TC Angel Tomlinson RN</p> <p>Census bed type: SNF/NF: 28 Total: 28</p> <p>Census payor type: Medicare: 1 Medicaid: 23 Other: 4 Total: 28</p> <p>Sample: 4</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review 1/14/13 by Suzanne Williams, RN</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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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>	F0157	This Plan of Correction constitutes the written allegation of compliance for the deficiencies cited.	02/03/2013			

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			<p>However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law.</p> <p>Hickory Creek at New Castle desires this Plan of Correction to be considered the facility's Allegation of Compliance. Compliance is effective on 2/3/13.</p> <p>-</p>		

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			<p><u>F157</u></p> <p>-</p> <p>It is the policy of this facility to notify the Physician of any change in resident condition, including abnormal or critical results of lab tests, such as PT/INR, and the facility's inability to complete a lab test as ordered by the physician.</p> <p><u>1. What corrective action will be done by the facility?</u></p> <p>-</p> <p><u>For Resident #C, the physician was notified on same day. Res. #C's PT/INR tests were repeated (per M.D. order) and the results were within acceptable limits.</u></p>	

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			<p><u>The M.D. .upon being notified of the lab results, then gave additional orders for continued medication dosing & when to repeat PT/INR testing. The resident was monitored and remained stable despite the critical lab values.</u></p> <p>-</p> <p><u>All facility nurses were informed and in-serviced of the event and the possible complications that could arise. The Physician's detailed clarifications were communicated to the nurses to ensure continuity of care for residents who are on anti-coagulation therapy.</u></p> <p><u>All nurses received disciplinary instruction on the correct procedure for receiving, writing, scheduling, reporting, & the proper notification of lab orders and lab test results.</u></p> <p>-</p> <p>-</p> <p>-</p> <p>-</p> <p>-</p> <p>-</p> <p>-</p>	

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			<p><u>The Nurse Consultant will re-train all licensed nurses during a mandatory in-service on 1/29/13. This inservice will address topics, as directed by ISDH, including the facility policies and procedures for rendering services as ordered by the physician, including testing and physician notification; the facility's expectation for a professional standard of care from the licensed nurses in utilizing the facility's policies and procedures as well as acceptable documentation for all findings and circumstances described in the 2567 The attendance, content, and resources used for this inservice will be forwarded to ISDH as directed.</u></p> <p><u>2. How will the facility identify other residents having the potential to be affected by the same practice and what corrective action will be taken?</u></p> <p>-</p> <p><u>There have been no other residents identified as being affected by this issue.</u></p> <p>-</p> <p><u>In the future, if any unmet needs or changes in condition, such as</u></p>		

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			<p><u>critical lab results that are not followed through as per policy, are identified by the DON or any member of the IDT, the DON will ensure that the physician is notified immediately. Once the physician has been notified, and the physician's orders have been followed through as the physician indicated to meet the resident's changing condition, the DON will retrain the nurses involved. In addition she will render progressive disciplinary action for continued noncompliance up to and including termination of employment.</u></p> <p><u>3. What measures will be put into place to ensure this practice does not recur?</u></p> <p>-</p> <p><u>The DON or IDT will review the nurses' notes, 24 hour report, and physician orders at the morning clinical meeting which is held at least five times per week, to make sure that physician notification and physician orders are being processed and followed through as appropriate. As part of this review lab tests and results of those lab tests will be checked and reviewed, too.</u></p>	

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			- - <u>Any recommendations or interventions formulated during the IDT review will be followed through by the DON or designee. The resident's care plan and CNA assignment sheet will be updated accordingly.</u> - <u>The Nurse Consultant will review the minutes of the morning clinical meeting, including the focus charting, 24 hour reports, physician orders, physician notification, lab tests and results, and other related areas at least weekly for the next 60 days. The Nurse Consultant, DON, and Administrator will review the results of these monitoring activities. Any identified issues will be addressed with staff at that time as indicated in question #2.</u> - - <u>4. How will corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place?</u> - The Administrator or DON	

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			<p>will bring the minutes of the IDT morning meetings and the results of the Nurse Consultant's audits to the monthly QA&A Committee meeting for review and recommendation. Any recommendations made by the committee will be followed through by the Administrator who will report the results of those recommendations at the next scheduled QA&A Committee meeting.</p> <p>The review of the focus charting, physician telephone orders, 24 hour report, physician notification, lab test results and follow through by the DON and IDT team will continue on an ongoing basis.</p> <p>The weekly Nurse Consultant audits may be discontinued by the QA&A Committee when 100% compliance is reached at</p>		

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	<p>Based on interview and record review, the facility failed to notify the physician when a resident's laboratory test PT/INR (labs to monitor the effects of Coumadin) were critical and to inform the physician that the facility would not be drawing the laboratory test as ordered by the physician, for 1 of 4 residents sampled for physician notification in a total sample of 4 (Resident #C).</p> <p>Finding include:</p> <p>Review of the record of Resident #C on 1-4-13 at 10:30 a.m. indicated the resident's diagnoses included, but were not limited to, atrial fibrillation (irregular heart beat), deep vein thrombosis (DVT), hypertension and gastrointestinal bleed (GI bleed).</p> <p>The physician order recapitulation for</p>		<p>least 2 weeks in a row after the 60 day period has ended. However, the Nurse Consultant will continue to check these areas as part of her regular visits to occur no less often than monthly on an ongoing basis.</p> <p>-</p> <p><u>Date of Compliance: 2/03/13</u></p>		

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	<p>Resident #C, dated January 2013, indicated the resident was ordered Coumadin 5 milligrams by mouth every day.</p> <p>The laboratory test for Resident #C dated 1-3-13 indicated the resident's Protime (PT) was 50.5 (high); the reference range was 9.2 to 11.0. The resident's INR (International Normalization Ratio) (bleeding time) was 4.6 (critically high); the reference range was 2.0 to 3.0.</p> <p>The telephone order for Resident #C, dated 1-3-12 indicated hold Coumadin on 1-3-13 and recheck 1-4-13 - no draws on Fridays per the physician- redraw on 1-7-13. The order was signed by LPN #1</p> <p>Interview with LPN #2 on 1-4-13 at 11:00 a.m. indicated Resident #C's PT/INR was not drawn.</p> <p>Interview with the Director of Nursing on 1-3-13 at 11:25 a.m. indicated Resident #C's PT/INR was not drawn on 1-4-13 because the physician did not want PT/INR labs drawn on Fridays. The DON indicated the physician's office nurse gave the order for the Coumadin to be held on 1-3-13 and for the PT/INR to be checked on 1-4-13. The DON</p>						

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	<p>indicated the facility changed the lab to 1-7-13, because the physician did not want the labs drawn on Fridays. The DON indicated she did not know if the physician was aware that Resident #C'S PT was high or that the INR was critically high. The DON indicated the resident was scheduled to receive her Coumadin on 1-4-13, 1-5-13 and 1-6-13 before the PT/INR would be rechecked on 1-7-13. The DON indicated the physician order indicated the Coumadin was to be held on 1-3-13 only.</p> <p>Interview with LPN #2 on 1-4-13 at 11:35 a.m. indicated the facility did not know if the physician was aware of Resident #C's PT/INR labs from 1-3-13 or that the PT/INR were not being drawn on 1-4-13. LPN #2 indicated the facility did not know if the physician was aware the resident was scheduled to receive her Coumadin on 1-4-13 without the PT/INR being checked.</p> <p>Interview with the physician for Resident #C on 1-4-13 at 11:55 a.m. indicated he was not aware that Resident #C had a critically high INR and that the resident's PT/INR labs were not going to be drawn until 1-7-13. The physician indicated he had never indicated to the facility that</p>						

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	<p>PT/INR's lab draws were not to be done on Fridays.</p> <p>Interview with LPN #1 on 1-4-13 at 4:40 p.m. indicated she changed the physician order for Resident #C to draw the PT/INR lab from 1-4-13 to 1-7-13, because the physician did not want PT/INR drawn on Fridays. LPN #1 indicated she did not have an order from the physician to not do PT/INR on Fridays, that it was wrote on the lab calendar not to do PT/INR'S on Fridays. LPN #1 indicated the physician had never verbally communicated to her directly that the labs were not to be done on Fridays.</p> <p>This deficiency was cited on 12-4-12. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>3.1-5(a)(2)</p>						

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F0282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.	F0282	F282 - It is the policy of this facility to provide services to all residents in accordance with physician's orders, including orders for lab tests. - <u>1. What corrective action will be done by the facility?</u> - <u>For Resident #C, the physician was notified on same day.</u> <u>Res. #C's PT/INR tests were re-peated (per M.D. order) and the results were within acceptable limits. The M.D. ,upon being notified of the lab results, then gave additional orders for continued medication dosing & when to repeat PT/INR testing. The resident was monitored and remained stable despite the critical lab values.</u>	02/03/2013	

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			<p>-</p> <p><u>All facility nurses were informed and in-serviced of the event and the possible complications that could arise. The Physician's detailed clarifications were communicated to the nurses to ensure continuity of care for residents who are on anti-coagulation therapy.</u></p> <p><u>All nurses received disciplinary instruction on the correct procedure for receiving, writing, scheduling, reporting, & the proper notification of lab orders and lab test results.</u></p> <p>-</p> <p>-</p> <p>-</p> <p>-</p> <p>-</p> <p>-</p> <p><u>The Nurse Consultant will re-train all licensed nurses during a mandatory in-service on 1/29/13. This inservice will address topics, as directed by ISDH, including the facility policies and procedures for rendering services as ordered by the physician, including testing and physician notification; the facility's expectation for a</u></p>	

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			<p><u>professional standard of care from the licensed nurses in utilizing the facility's policies and procedures as well as acceptable documentation for all findings and circumstances described in the 2567, including the procedure for handling faxed orders from the physician and the correct way for nurses to write notations on the faxed order sheet itself. The attendance, content, and resources used for this inservice will be forwarded to ISDH as directed.</u></p> <p><u>2. How will the facility identify other residents having the potential to be affected by the same practice and what corrective action will be taken?</u></p> <p>-</p> <p><u>There have been no other residents identified as being affected by this</u></p> <p><u>issue.</u></p> <p>-</p> <p><u>In the future, if any unmet needs or changes in condition, such as critical lab results that are not followed through as per policy, are identified by the DON or any member of the IDT, the DON will ensure that the physician is notified immediately. Once the</u></p>	

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			<p><u>physician has been notified, and the physician's orders have been followed through as the physician indicated to meet the resident's changing condition, the DON will retrain the nurses involved. In addition she will render progressive disciplinary action for continued noncompliance up to and including termination of employment.</u></p> <p><u>3. What measures will be put into place to ensure this practice does not recur?</u></p> <p>-</p> <p><u>The DON or IDT will review the nurses' notes, 24 hour report, and physician orders, including any faxed orders, at the morning clinical meeting which is held at least five times per week, to make sure that physician notification and physician orders are being processed and followed through as appropriate. As part of this review lab tests and results of those lab tests will be checked and reviewed, too.</u></p> <p>-</p> <p>-</p> <p><u>Any recommendations or interventions formulated during</u></p>	

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			<p><u>the IDT review will be followed through by the DON or designee. The resident's care plan and CNA assignment sheet will be updated accordingly.</u></p> <p>-</p> <p><u>The Nurse Consultant will review the minutes of the morning clinical meeting, including the focus charting, 24 hour reports, physician orders including faxed orders, physician notification, lab tests and results, and other related areas at least weekly for the next 60 days. The Nurse Consultant, DON, and Administrator will review the results of these monitoring activities. Any identified issues will be addressed with staff at that time as indicated in question #2.</u></p> <p>-</p> <p>-</p> <p><u>4. How will corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place?</u></p> <p>-</p> <p>The Administrator or DON will bring the minutes of the IDT morning meetings and the results of the Nurse Consultant's audits to the</p>	

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			<p>monthly QA&A Committee meeting for review and recommendation. Any recommendations made by the committee will be followed through by the Administrator who will report the results of those recommendations at the next scheduled QA&A Committee meeting.</p> <p>The review of the focus charting, physician telephone and faxed orders, 24 hour report, physician notification, lab test results and follow through by the DON and IDT team will continue on an ongoing basis.</p> <p>The weekly Nurse Consultant audits may be discontinued by the QA&A Committee when 100% compliance is reached at least 2 weeks in a row after the 60 day period has ended. However, the Nurse Consultant will continue to</p>		

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	<p>Based on interview and record review, the facility failed to follow a physician order to draw PT/INR (laboratory tests to monitor the effects of Coumadin, a blood-thinning medication), for 1 of 4 residents sampled for following physician orders in a total sample of 4 (Resident #C).</p> <p>Finding includes:</p> <p>Review of the record of Resident #C on 1-4-13 at 10:30 a.m. indicated the resident's diagnoses included, but were not limited to, atrial fibrillation (irregular heart beat), deep vein thrombosis (DVT), hypertension and gastrointestinal bleed (GI bleed).</p> <p>The physician order recapitulation for Resident #C, dated January 2013, indicated the resident was ordered Coumadin 5 milligrams by mouth every day.</p> <p>The laboratory test for Resident #C</p>		<p>check these areas as part of her regular visits to occur no less often than monthly on an ongoing basis.</p> <p>-</p> <p><u>Date of Compliance: 2/03/13</u></p>		

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	<p>dated 1-3-13 indicated the resident's Protime (PT) was 50.5 (high); the reference range was 9.2 to 11.0. The resident's INR (International Normalization Ratio) (bleeding time) was 4.6 (critically high); the reference range was 2.0 to 3.0.</p> <p>The telephone order for Resident #C, dated 1-3-12 indicated hold Coumadin on 1-3-13 and recheck 1-4-13 - no draws on Fridays per the physician- redraw on 1-7-13. The order was signed by LPN #1</p> <p>Interview with LPN #2 on 1-4-13 at 11:00 a.m. indicated Resident #C's PT/INR was not drawn.</p> <p>Interview with the Director of Nursing on 1-3-13 at 11:25 a.m. indicated Resident #C's PT/INR was not drawn on 1-4-13 because the physician did not want PT/INR labs drawn on Fridays. The DON indicated the physician's office nurse gave the order for the Coumadin to be held on 1-3-13 and for the PT/INR to be checked on 1-4-13. The DON indicated the facility changed the lab to 1-7-13, because the physician did not want the labs drawn on Fridays. The DON indicated she did not know if the physician was aware that Resident #C'S PT was high or that</p>				

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	<p>the INR was critically high. The DON indicated the resident was scheduled to receive her Coumadin on 1-4-13, 1-5-13 and 1-6-13 before the PT/INR would be rechecked on 1-7-13. The DON indicated the physician order indicated the Coumadin was to be held on 1-3-13 only.</p> <p>Interview with LPN #2 on 1-4-13 at 11:35 a.m. indicated the facility did not know if the physician was aware of Resident #C's PT/INR labs from 1-3-13 or that the PT/INR were not being drawn on 1-4-13. LPN #2 indicated the facility did not know if the physician was aware the resident was scheduled to receive her Coumadin on 1-4-13 without the PT/INR being checked.</p> <p>Interview with the physician for Resident #C on 1-4-13 at 11:55 a.m. indicated he was not aware that Resident #C had a critically high INR and that the resident's PT/INR labs were not going to be drawn until 1-7-13. The physician indicated he had never indicated to the facility that PT/INR's lab draws were not to be done on Fridays.</p> <p>Interview with the physician office nurse on 1-4-13 at 2:33 p.m. indicated the office had given an</p>						

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	<p>order on 1-3-13 for Resident #C's Coumadin to be held on 1-3-13 and for the PT/INR to be rechecked on 1-4-13. The office nurse indicated the order was faxed to the facility. The office nurse indicated the physician had not requested to her knowledge for PT/INR not to be drawn on Fridays. The office nurse indicated Resident #C's PT/INR should have been drawn on 1-4-13 due to the INR being 4.6.</p> <p>A fax dated 1-3-13 at 9:51 a.m. for Resident #C indicated "hold today, recheck in a.m." on 1-4-13. Under the order in different hand writing, it indicated "no draws on Fridays per the physician, changed to 1-7-13," with no initials or signature.</p> <p>Interview with LPN #1 on 1-4-13 at 4:40 p.m. indicated she changed the physician order for Resident #C to draw the PT/INR lab from 1-4-13 to 1-7-13, because the physician did not want PT/INR drawn on Fridays. LPN #1 indicated she did not have an order from the physician to not do PT/INR on Fridays, that it was wrote on the lab calendar not to do PT/INR'S on Fridays. LPN #1 indicated the physician had never verbally communicated to her directly that the labs were not to be done on</p>						

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	<p>Fridays.</p> <p>This deficiency was cited on 12-4-12. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>3.1-35(g)(2)</p>			

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F0329 SS=D	<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 adequately monitor laboratory tests ordered by the physician to monitor the effects of Coumadin (blood thinning medication) therapy after PT/INR results were high, resulting in the resident scheduled to receive Coumadin without a recheck of the resident's labwork, for 1 of 3 residents sampled for Coumadin therapy in a total sample of 4 (Resident #C).</p>	F0329	<p><u>F329</u></p> <p>-</p> <p>-</p> <p><u>It is the policy of this facility to make sure that each resident's drug regimen is free from unnecessary drugs, including the adequate monitoring of laboratory tests as ordered by the physician to monitor the effects of Coumadin therapy after an abnormally high PT/INR, so that</u></p>	02/03/2013	

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	<p>Finding include:</p> <p>Review of the record of Resident #C on 1-4-13 at 10:30 a.m. indicated the resident's diagnoses included, but were not limited to, atrial fibrillation (irregular heart beat), deep vein thrombosis (DVT), hypertension and gastrointestinal bleed (GI bleed).</p> <p>The physician order recapitulation for Resident #C, dated January 2013, indicated the resident was ordered Coumadin 5 milligrams by mouth every day.</p> <p>The laboratory test for Resident #C dated 1-3-13 indicated the resident's Protime (PT) was 50.5 (high); the reference range was 9.2 to 11.0. The resident's INR (International Normalization Ratio) (bleeding time) was 4.6 (critically high); the reference range was 2.0 to 3.0.</p> <p>The telephone order for Resident #C, dated 1-3-12 indicated hold Coumadin on 1-3-13 and recheck 1-4-13 - no draws on Fridays per the physician- redraw on 1-7-13. The order was signed by LPN #1</p> <p>Interview with LPN #2 on 1-4-13 at 11:00 a.m. indicated Resident #C's PT/INR was not drawn.</p>		<p><u>the resident does not receive medication without a recheck of the laboratory test as ordered by the physician.</u></p> <p>-</p> <p><u>1. What corrective action will be done by the facility?</u></p> <p>-</p> <p><u>For Resident #C, the physician was notified. Res. #C's PT/INR tests were repeated (per M.D. order) and the results were within acceptable limits. The M.D., upon being notified of the lab results, then gave additional orders for continued medication dosing & when to repeat PT/INR testing. The resident was monitored and remained stable despite the critical lab values.</u></p> <p>-</p> <p><u>All facility nurses were informed and in-serviced of the event and the possible complications that could arise. The Physician's detailed clarifications were communicated to the nurses to ensure continuity of care for residents who are on anti-coagulation therapy.</u></p> <p><u>All nurses received disciplinary instruction on the correct procedure for receiving, writing, scheduling, reporting, & the proper notification of lab orders</u></p>		

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	<p>Interview with the Director of Nursing on 1-3-13 at 11:25 a.m. indicated Resident #C's PT/INR was not drawn on 1-4-13 because the physician did not want PT/INR labs drawn on Fridays. The DON indicated the physician's office nurse gave the order for the Coumadin to be held on 1-3-13 and for the PT/INR to be checked on 1-4-13. The DON indicated the facility changed the lab to 1-7-13, because the physician did not want the labs drawn on Fridays. The DON indicated she did not know if the physician was aware that Resident #C'S PT was high or that the INR was critically high. The DON indicated the resident was scheduled to receive her Coumadin on 1-4-13, 1-5-13 and 1-6-13 before the PT/INR would be rechecked on 1-7-13. The DON indicated the physician order indicated the Coumadin was to be held on 1-3-13 only.</p> <p>Interview with LPN #2 on 1-4-13 at 11:35 a.m. indicated the facility did not know if the physician was aware of Resident #C's PT/INR labs from 1-3-13 or that the PT/INR were not being drawn on 1-4-13. LPN #2 indicated the facility did not know if the physician was aware the resident was scheduled to receive her</p>		<p><u>and lab test results.</u></p> <p>-</p> <p>-</p> <p><u>The Nurse Consultant will re-train all licensed nurses during a mandatory in-service on 1/29/13. This in-service will address topics, as directed by ISDH, including the facility policies and procedures for rendering services as ordered by the physician, including testing and physician notification; the facility's expectation for a professional standard of care from the licensed nurses in utilizing the facility's policies and procedures as well as acceptable documentation for all findings and circumstances described in the 2567, including the procedure for handling faxed orders from the physician and the correct way for nurses to write notations on the faxed order sheet itself. The attendance, content, and resources used for this inservice will be forwarded to ISDH as directed.</u></p> <p><u>2. How will the facility identify other residents having the potential to be affected by the same practice and what corrective action will be taken?</u></p> <p>-</p>				

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	<p>Coumadin on 1-4-13 without the PT/INR being checked.</p> <p>Interview with LPN #1 on 1-4-13 at 11:50 a.m. indicated Resident #C's Coumadin was held on 1-3-13. LPN #1 indicated she knew the resident's PT/INR was supposed to be re drawn before the Coumadin was given again. LPN #1 indicated the physician office nurses had ordered for Resident #C's Coumadin to be held and rechecked on 1-4-13. LPN #1 indicated the physician did not want PT/INR drawn on Fridays and she was unsure why. LPN #1 indicated she did attempt to call the physician on 1-3-13, but was unable to get an answer. LPN #1 indicated she passed it on to the next shift nurse that the physician did not want PT/INR drawn on Fridays and the lab could be drawn on 1-7-13 Monday.</p> <p>Interview with the physician for Resident #C on 1-4-13 at 11:55 a.m. indicated he was not aware that Resident #C had a critically high INR and that the resident's PT/INR labs were not going to be drawn until 1-7-13. The physician indicated he had never indicated to the facility that PT/INR's lab draws were not to be done on Fridays.</p>		<p><u>There have been no other residents identified as being affected by this issue.</u></p> <p>-</p> <p>-</p> <p><u>In the future, if any unmet needs or changes in condition, such as critical lab results that are not followed through as per policy, are identified by the DON or any member of the IDT, the DON will ensure that the physician is notified immediately. Once the physician has been notified, and the physician's orders have been followed through as the physician indicated to meet the resident's changing condition, the DON will retrain the nurses involved. In addition she will render progressive disciplinary action for continued noncompliance up to and including termination of employment.</u></p> <p><u>3. What measures will be put into place to ensure this practice does not recur?</u></p> <p>-</p> <p>The DON or IDT will review the</p>				

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	<p>Interview with the physician on 1-4-13 at 1:05 p.m. indicated the office nurses decide if a PT/INR needs rechecked. The physician indicated he had called the facility and told them to recheck Resident #C's PT/INR levels done today. The physician indicated he had a problem in the past with the facility getting PT/INR lab on Friday afternoon and had requested that they get the lab draws in the morning if possible so someone would be in his office to receive the results. The physician indicated he had never put in writing or ordered for PT/INR's not to be done on Fridays.</p> <p>Interview with the physician office nurse on 1-4-13 at 2:33 p.m. indicated the office had given an order on 1-3-13 for Resident #C's Coumadin to be held on 1-3-13 and for the PT/INR to be rechecked on 1-4-13. The office nurse indicated the order was faxed to the facility. The office nurse indicated the physician had not requested to her knowledge for PT/INR not to be drawn on Fridays. The office nurse indicated Resident #C's PT/INR should have been drawn on 1-4-13 due to the INR being 4.6.</p> <p>Interview with LPN #2 on 1-4-13 at</p>		<p><u>nurses' notes, 24 hour report, and physician orders, including any faxed orders, at the morning clinical meeting which is held at least five times per week, to make sure that physician notification and physician orders are being processed and followed through as appropriate. As part of this review lab tests and results of those lab tests will be checked and reviewed, too.</u></p> <p>-</p> <p><u>Any recommendations or interventions formulated during the IDT review will be followed through by the DON or designee. The resident's care plan and CNA assignment sheet will be updated accordingly.</u></p> <p>-</p> <p><u>The Nurse Consultant will review the minutes of the morning clinical meeting, including the focus charting, 24 hour reports, physician orders including faxed orders, physician notification, lab tests and results, and other related areas at least weekly for the next 60 days. The Nurse Consultant, DON, and Administrator will review the results of these monitoring activities. Any identified issues will be addressed with staff at that time as indicated in question #2.</u></p> <p>-</p>				

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	<p>1:55 p.m. indicated the reason the facility did not obtain Resident #C's PT/INR was because the physician had indicated in the past that he did not want them done on Fridays because he could not guarantee that there would be someone in his office to receive the lab results.</p> <p>Interview with RN #3 on 1-4-13 at 2:00 p.m. indicated she knew not to get any PT/INR's drawn on Fridays, because it was written in the lab calendar not to, per the physician.</p> <p>Interview with the DON on 1-4-13 at 2:05 p.m. indicated she found out about not doing PT/INR labs on Fridays from the facility nurses. The DON indicated the first time she had seen it written in the lab calendar book was November 9, 2012. The DON indicated she did not know who wrote it in the lab calendar book. The DON indicated she had not talked to the physician about not drawing PT/INR's on Fridays. Review of lab calendar book at this time indicated on 11-9-12 "No PT/INR's on Fridays" per the physician, there was no signature who wrote the documentation.</p> <p>A fax dated 1-3-13 at 9:51 a.m. for Resident #C indicated "hold today,</p>		<p>-</p> <p><u>4. How will corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place?</u></p> <p>-</p> <p>The Administrator or DON will bring the minutes of the IDT morning meetings and the results of the Nurse Consultant's audits to the monthly QA&A Committee meeting for review and recommendation. Any recommendations made by the committee will be followed through by the Administrator who will report the results of those recommendations at the next scheduled QA&A Committee meeting.</p> <p>The review of the focus charting, physician telephone and faxed orders, 24 hour report, physician notification, lab test results and follow through by the DON and IDT team will continue on</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155459	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/04/2013
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	<p>recheck in a.m." on 1-4-13. Under the order in different hand writing, it indicated "no draws on Fridays per the physician, changed to 1-7-13," with no initials or signature.</p> <p>Interview with LPN #1 on 1-4-13 at 4:40 p.m. indicated she changed the physician order for Resident #C to draw the PT/INR lab from 1-4-13 to 1-7-13, because the physician did not want PT/INR drawn on Fridays. LPN #1 indicated she did not have an order from the physician to not do PT/INR on Fridays, that it was wrote on the lab calendar not to do PT/INR'S on Fridays. LPN #1 indicated the physician had never verbally communicated to her directly that the labs were not to be done on Fridays.</p> <p>3.1-48(a)(3)</p>		<p>an ongoing basis.</p> <p>The weekly Nurse Consultant audits may be discontinued by the QA&A Committee when 100% compliance is reached at least 2 weeks in a row after the 60 day period has ended. However, the Nurse Consultant will continue to check these areas as part of her regular visits to occur no less often than monthly on an ongoing basis.</p> <p>-</p> <p><u>Date of Compliance: 2/03/13</u></p> <p>-</p>		