STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 05/14/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTH AT PRESTWICK	182 S CR 550 E AVON, IN 46123

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R0000	This visit was for Investigation of Complaint IN00103868 and IN00104216. Complaint IN00103868: Substantiated, state residential finding related to the allegation is cited at R0242 Complaint IN00104216: Substantiated, state residential finding related to the allegation is cited at R0006. Dates of survey: May 10, 11 and 14, 2012 Facility number: 003902 Provider number: 003902 AIM number: NA Survey team: Vanda Phelps, R.N. Census bed type: Residential 134 Total 134 Census payor type: Other 134 Total 134 Sample: 7 These state findings are cited in	R0000		

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

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	accordance with 410 IAC 16.2. Quality review completed on May 21, 2012 by Bev Faulkner, RN			

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R0006	410 IAC 16.2-5-0.5(f)(1-5) Scope of Residential Care - Deficiency (f) The resident must be discharged if the resident: (1) is a danger to the resident or others; (2) requires twenty-four (24) hour per day comprehensive nursing care or comprehensive nursing oversight; (3) requires less than twenty-four (24) hour per day comprehensive nursing care, comprehensive nursing oversight, or rehabilitative therapies and has not entered into a contract with an appropriately licensed provider of the resident ' s choice to provide those services; (4) is not medically stable; or (5) meets at least two (2) of the following three (3) criteria unless the resident is medically stable and the health facility can meet the resident ' s needs: (A) Requires total assistance with eating. (B) Requires total assistance with toileting. (C) Requires total assistance with transferring. Based on record review and interviews, the facility failed to discharge residents timely when care requirements were demonstrated to be beyond the scope of care provided by this residential facility. This practice presented a potential danger to 2 of 7 residents reviewed. (Residents H and N) Findings include: 1. Resident N's closed clinical record was reviewed on 5/14/12 at 2:15 p.m. It indicated his diagnoses included, but were	R0006	The corrective action to be accomplished will be to discharge resident (H) by issuing notice to resident (H) and POA/responsible party. This notice will serve as a 30 day or appropriate placement notice. Resident (N) was discharged from facility on 2/17/2012.A review of all residents and their service assessments will be completed to determine if there are any other residents requiring services beyond The Hearth's scope of care and staffing.For all new inquiries for possible admission to The Hearth, the Resident Services Coordinator will work	07/08/2012

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	not limited to, dementia with behavioral disturbances and irritable bowel syndrome. He was a resident of the dementia unit. The nursing notes throughout January and February of 2012, indicated his cognition was very impaired and he was unable to communicate his needs. The nursing note of 1/20/12 at 10:30 a.m., indicated Resident N had begun choking at breakfast and then had uncontrollable coughing and finally vomited five times. "...Res (resident) c/o (complained of) difficulty breathing for several minutes after vomiting but was able to regulate breathing..." Another entry at 12:30 p.m., indicated the same type of incident happened at lunch. On 1/20/12, the M.D. ordered a speech therapy evaluation which was done 1/24/12. The Speech Therapist recommended the resident be fed slowly and avoid large bites and to make sure the resident had swallowed before he was given another bite. Resident N's severe cognitive impairment caused him not to understand that he was causing the coughing when he ate huge bites much too fast, did not swallow before putting more food in and talking with food in his mouth. LPN #3 documented that she fed lunch to Resident N and thus controlled how fast he was eating and the size of the bites and		with the Director of Nursing and the Executive Director to determine if the potential resident meets requirements for residential care. For current Hearth residents, the service assessments are completed/updated every 6 months and/or upon change of condition. At that time, the resident will be evaluated to determine if the resident remains appropriate for residential care.The Resident Services Coordinator completes resident service assessments every 6 months and/or upon change of condition. The Director of Nursing or designee will perform random audits on resident service assessments to determine appropriateness for residential care. Six (6) audits will be completed each month for the next three consecutive months. Systemic changes to be completed by July 8, 2012.	

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	he did well. Thereafter, daily entries documented this resident choked and vomited with nearly every meal, usually accompanied with some difficulty breathing. This continued until he was transferred to a long term care facility on 2/17/12. Interview with the Director of Nursing on 5/14/12 at 3:45 p.m., indicated the family had not wanted him to be moved to a regular nursing home and insisted he stay at the assisted living facility even though they knew about the choking and vomiting. She indicated staff had repeatedly explained how dangerous it was for the resident and that he could choke to death or aspirate, but they (the family) were adamant. The Director of Nursing indicated their services did not include routinely feeding a resident and therefore, Resident N had not been fed by staff other than the one time. 2. The clinical record of Resident H was reviewed on 5/11/12 at 2:40 p.m. It indicated she was admitted on 12/14/11 with diagnoses which included, but were not limited to, Charcot Marie Tooth disease, muscle weakness, peroneal muscle atrophy and recurrent urinary tract infections. Charcot Marie Tooth disease and peroneal muscle atrophy are			

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	progressive neurological diseases impacting bones and muscles. The form titled "Nursing Comprehensive Evaluation" at admission and again on 1/12/12 indicated this resident needed the assistance of three staff members for toileting and transfers and the resident did not ambulate. She was incontinent of urine and had a colostomy. She had a pressure area on her coccyx. It was noted she was "totally dependent on staff for all transfers." Her diagnoses indicated this resident's physical abilities will continue to decline. Review of the current staffing pattern indicated that for the assisted living section of the facility, which is on three floors, they routinely staff two nurses and two aides for the day and evening shifts and one nurse and one aide on the night shift. During confidential interviews with selected nursing staff on May 10, 11 and 14, 2012, they indicated it was rarely possible to have three staff available at the same time to transfer Resident H or to assist her with toileting and that she and her family frequently complained about her having to wait extended periods of time for assistance to arrive. They indicated this assisted living facility does not allow the use of mechanical lifts or slide boards for transfers or bedpans for toileting.			

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	These State Residential Rule findings relate to complaint IN00104216.			

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R0242	410 IAC 16.2-5-4(e)(2) Health Services - Offense (2) The resident shall be observed for effects of medications. Documentation of any undesirable effects shall be contained in the clinical record. The physician shall be notified immediately if undesirable effects occur, and such notification shall be documented in the clinical record. Based on record review and interviews, the facility lacked a system in place to monitor anti-coagulation medication levels to assure they were within a therapeutic range. This impacted 4 of 4 residents reviewed regarding Coumadin/Warfarin administration and monitoring in the total sample of 7 residents This included 3 of 3 current residents receiving Coumadin. (Residents D, R, S and T) Findings include: 1. The closed clinical record of Resident D was reviewed on 5/11/12 at 11:29 a.m. The record indicated she'd been admitted on 7/1/10 with diagnoses including, but not limited to, atrial fibrillation and mitral valve replacement. This review indicated Resident D had been on Coumadin since admission 7/1/10. Further review indicated there was no evidence laboratory testing to monitor the effect of the Coumadin had occurred in the six month period of 2/22/11 to 8/26/11;	R0242	The corrective action to be accomplished will be to implement a system to monitor anti-coagulation medication levels and to assure the levels are being properly monitored and assessed by the designated physician of each resident. Resident (D) no longer resides at The Hearth. Resident (R) is currently in rehabilitation in another facility. Resident (T) PT/INR orders reviewed and has current PT/INR order and will continue to be monitored. Resident (S) no longer resides at The Hearth.A review of all residents currently on anti-coagulation medication will be completed to ensure proper PT/INR orders are in place and that the results are being monitored by the designated physician.A PT/INR monitoring system will be implemented. A binder for each unit will be created with all residents on anti-coagulation medication listed on a sheet. On this sheet there will be a place for each resident's name, draw dates, a check box for labs received, a check box for orders received, and a new draw date. This binder will be used by	07/08/2012

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	although she was receiving Coumadin daily during that time. There was no evidence the facility was aware of this lapse until a family member called it to their attention. 2. Resident R's clinical record was reviewed on 5/14/12 at 12:30 p.m. The record indicated he was admitted on 9/24/10 with diagnoses including, but not limited to, end stage renal disease with hemodialysis three times weekly, insulin dependent diabetes, and peripheral vascular disease. There was a physician's order, dated 8/18/11, for a PT/INR to be drawn by the dialysis unit every Monday. Further review indicated there were no PT/INR reports within his record. The facility had no way of knowing whether or not the lab test was being drawn as ordered or the results. There was no evidence the attending physician had received and reviewed these results. Interview with the Director of Nursing on 5/14/12 at 3:45 p.m., indicated she would contact the dialysis unit about this issue. 3. The clinical record of Resident T was reviewed on 5/14/12 at 12 noon. The record indicated she was admitted on 6/2/10 with diagnoses including, but not limited to, congestive heart disease, history of pulmonary embolism and venous thrombosis. She was receiving		all nurses receiving new Coumadin/PT/INR orders. Training will be provided and completed with all nurses on the proper use of the binder.The Unit Managers for each unit will monitor binders weekly to ensure PT/INR levels are being properly monitored and addressed by the designated physicians.Systematic changes to be completed by July 8, 2012.	

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	Warfarin 7.5 mg (milligrams) every Monday, Wednesday and Friday plus Warfarin 5 mg. on Tuesday, Thursday, Saturday and Sunday. She had physician orders for other blood tests to be done monthly, but no current order for her next PT/INR. Review of the lab reports indicated there had been PT/INRs for 2/14/12, 2/21/12, and 4/10/12, but none between 2/21/12 and 4/10/12. The PT/INR report of 4/10/12 indicated the M.D. had initialed the page to indicate he had seen it. The current Warfarin dose was written of the form, and a notation "0 changes." The line marked "next INR due" was blank. As of 5/14/12, which was 35 days later, no further testing had been done. During interview with the Director of Nursing at 3:45 p.m. on 5/14/12, she indicated all physician orders would be contained in the resident's record. They were not kept anywhere else. 4. Resident S's clinical record was reviewed on 5/11/12 at 10:25 a.m. It indicated he was admitted on 9/12/09 with diagnoses including, but not limited to, chronic atrial fibrillation, stroke in 2009, cardiomyopathy, and aortic valve replacement 2001. He was currently receiving Warfarin 2.5 mg. (milligrams) on Mondays, Thursdays and Saturdays			

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	plus 2.5 mg. on Sundays, Tuesdays, Wednesdays and Fridays. His last PT/INR of record was dated 4/10/12. He did not have a physician order for further PT/INRs, although he continued to receive Warfarin daily. 5. Interview of Unit Manager #1 on 5/11/12 at 1:15 p.m., indicated there was no specific protocol to follow regarding the tracking of lab orders to assure they were done, received and followed up. She indicated some nurses wrote the lab order on a calendar, but not all followed that system. She offered no explanation for how Resident D had gone so long without anyone noticing PT/INRs were not being done. She said, "She didn't have an order." 6. Interview with the Director of Nursing on 5/14/12 at 3:45 p.m., indicated she had been concerned why the monthly pharmacy review had not alerted her to this problem and why the monthly physician rewrite reviews had also allowed the problem to go unnoticed. 7. The 2101 Nursing Spectrum Drug Handbook was reviewed on 5/16/12 at 10 p.m. On page 1238 the entry regarding the anticoagulant Warfarin/Coumadin contained a black box warning: "Drug may cause major or fatal bleeding.			

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	Bleeding is more likely during starting period and with higher dosage (resulting in higher International Normalized Ratio (INR). Monitor INR regularly in all patients. Those at high risk for bleeding may benefit from more frequent INR monitoring, careful dosage adjustment, and shorter duration of therapy...." Review 5/15/12 at 11:30 a.m. of information located at PT/INR on Google indicated PT/INR is a blood test used to monitor the effectiveness of anticoagulants such as Warfarin/Coumadin. The initials stand for Prothrombin Time/International Normalized Ratio. Review of the Medication Administration Records on 5/10/12 at 3:05 p.m., indicated there were three current residents receiving Coumadin. Each of these resident's records were reviewed in addition to a closed record of a resident who had been on Warfarin while in the facility. These State Residential Rule findings relate to complaint IN00103868.			