

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155328	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/10/2014
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NAME OF PROVIDER OR SUPPLIER WESTPARK REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 25 S BOEHNE CAMP RD EVANSVILLE, IN 47712
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F000000	<p>This visit was for the Investigation of Complaint IN00IN146067 and Complaint IN00146820.</p> <p>Complaint IN00146067 - Substantiated, Federal/State deficiencies are cited at F225 and F226.</p> <p>Complaint IN00146820 - Substantiated, Federal/State deficiencies are cited at F271, F329, and F514.</p> <p>Survey dates: April 8, 9, and 10, 2014</p> <p>Facility number: 000221 Provider number: 155328 AIM number: 100267620</p> <p>Survey team: Anne Marie Crays RN</p> <p>Census bed type: SNF/NF: 84 Total: 84</p> <p>Census payor type: Medicare: 23 Medicaid: 51 Other: 10 Total: 84</p> <p>Sample: 10</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed on April 16, 2014</p>	F000000	The Preparation or execution of this plan of correction does not constitute admission of agreement by the provider of the truth of the facts alleged or conclusions set forth on the statement of deficiencies. The plan of correction is prepared and executed solely because it is required by federal and state law. We respectfully request this Plan of Correction serve as our allegation of compliance.	

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

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	<p>Based on interview and record review, the facility failed to report an allegation of verbal abuse to the Indiana State Department of Health (ISDH), for 1 of 6 residents reviewed for verbal abuse, in a sample of 10. Resident B</p> <p>Findings include:</p> <p>1. The clinical record of Resident B was reviewed on 4/9/14 at 2:45 P.M. Diagnoses included, but were not limited to, acute CVA.</p> <p>Nurse's notes included the following notations:</p> <p>3/16/14 at 9:30 A.M.: "Res [resident's] mother approached this nurse in hallway et [and] stated, 'I am so p----d off, I can't even see straight!' This nurse asked what was bothering res. Mother stated, 'That male CNA is not allowed in [Resident B's] room anymore. He told [Resident B] that he was a dog! I could just choke the s--t out of him!' This nurse asked the mother for further details of the statement made. Mother stated, 'That CNA told [Resident B] that he eats so fast he is like a dog who is thrown a piece of bologna. I am going to make him pay for all the pain et troubles he has caused [Resident B]...!' This nurse told mother that the issue could be reported to weekend manager et would relay message that mother would like to talk to manager. CNA wrote down statement of what was said to [Resident B] the night before. Statement given to weekend manager."</p> <p>On 4/10/14 at 11:05 A.M., during interview with the Social Services Director (SSD), she</p>	F000225	F 225 The incident of alleged verbal abuse involving resident B was reported to the ISDH on 4-28-14. After investigation, the incident was determined to not be verbal abuse. Incidents that alleged verbal abuse involving residents that reside at the facility have been and will be reported as required by Federal and State regulations and per the facilities policy. Incidents of allege verbal abuse involving residents that reside at the facility have been and will be reported as required by Federal and State regulations and per facility policy. After reporting the incident, the IDT team investigates allegations of abuse to determine if the incidents are valid. Appropriate corrective action will be taken as needed. Staff have been re-educated on the policy and procedure of resident abuse. Reports filed with the ISDH will be reviewed during monthly QAPI meetings. This will be ongoing.	05/10/2014			

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	<p>indicated Resident B's mother reported to RN # 1 that CNA # 1 called Resident B a dog, then said Resident B ate like a dog. The SSD indicated CNA # 1 was not talking to Resident B, but that apparently 2 visitors in the resident's room asked the CNA how the resident was eating. The SSD indicated the friends must have informed the resident's mother of the comment. The SSD indicated it was a bad analogy and was inconsiderate, but that she didn't consider it abuse. The SSD indicated RN # 1 called in the Admissions Coordinator, who was the weekend manager, who came in and spoke with the resident's mother. She indicated the staff was inserviced on communication skills.</p> <p>At that time, the SSD provided documentation, which included the following statement from the Admissions Coordinator: "3/16/14 @ 4:00 p [RN # 1] brought to my attention a concern re: [Resident B] per his mother & that she would like to speak to weekend manager. I went down to unit and spent over 1 hr speaking with her regarding her concern. She stated [CNA # 1] called her son a 'dog.' She then went on to say that he made a reference comparing her son to a dog. She stated that she was told by friends visiting [Resident B] what was said. The visitors stated to mother that they asked about [Resident B's] eating & how he was doing since being released from speech therapy. I spoke to [CNA # 1] regarding the conversation at which time he wrote me a statement...I met with staff on skilled & inserviced them on tone, conversations, manners, & 'joking' with residents, staff, families, visitors. I immediately switched the CNA's [sic] to where [CNA # 1] would not be caring for [Resident B] rest of shift & asked [RN # 1] to document any other</p>			

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	<p>issues/conversations. Once I completed inservice, I called ED [Administrator] & informed him of concern, as well as actions taken to resolve it."</p> <p>On 4/10/14 at 11:30 A.M., the Admissions Coordinator was interviewed. She indicated she was the weekend manager working on March 16, 2013. She indicated RN # 1 called her and told her Resident B's mother was upset and wanted to talk to her. The Admissions Coordinator indicated the resident's mother told her, "That CNA called [Resident B] a dog." She then indicated the mother said the CNA "compared [Resident B] to a dog." The Admissions Coordinator indicated the mother had multiple complaints. She indicated the resident had 2 friends visiting in his room, and the visitors asked CNA # 1 how the resident was eating. The CNA indicated, "It's like a dog going after bologna," because the resident ate so quickly. The Admissions Coordinator indicated the mother was not present, but the visitors or the resident must have called the mother. The Admissions Coordinator indicated she inserviced staff, and told CNA # 1 to stay out of the resident's room. She indicated she informed the Administrator of the situation, but did not consider it an abuse situation.</p> <p>On 4/10/14 at 2:00 P.M., during interview with the Administrator, he indicated he did not report the allegation to the ISDH, because he did not think it was abuse. He indicated the Admissions Coordinator had called him that day and informed him of the concern and how she had handled it.</p> <p>2. On 4/8/14 at 9:40 A.M., the Administrator provided the current facility policy on</p>			

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F000226 SS=D	<p>"Prevention and Reporting: Resident Mistreatment, Neglect, Abuse....," revised April 2013. The policy included: "...All allegations that meet the definition of abuse and substantiated violations will be reported to state agencies...as required...Verbal abuse is oral, written, or gestured language that includes disparaging and derogatory terms to the resident or their families or within their hearing distance regardless of their age, ability to comprehend or disability...."</p> <p>This Federal tag relates to Complaint IN00146067.</p> <p>3.1-28(c) 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.</p> <p>Based on interview and record review, the facility failed to implement their policy to report an allegation of verbal abuse to the Indiana State Department of Health (ISDH), for 1 of 6 residents reviewed for verbal abuse, in a sample of 10. Resident B</p> <p>Findings include:</p> <p>1. The clinical record of Resident B was reviewed on 4/9/14 at 2:45 P.M. Diagnoses included, but were not limited to, acute CVA.</p> <p>Nurse's notes included the following notations:</p>	F000226	F 226 The incident of alleged verbal abuse involving resident B was reported to the ISDH on 4-28-14. The incident was determined not to be verbal abuse. Incidents that alleged verbal abuse involving residents that reside at the facility have been and will be reported as required by Federal and State regulations and per facility policy. Incidents of allege verbal abuse involving residents that reside at the facility have been and will be reported as required by Federal and State regulations and per facility policy. After reporting the incident the IDT team investigates	05/10/2014			

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	<p>3/16/14 at 9:30 A.M.: "Res [resident's] mother approached this nurse in hallway et [and] stated, 'I am so p----d off, I can't even see straight!' This nurse asked what was bothering res. Mother stated, 'That male CNA is not allowed in [Resident B's] room anymore. He told [Resident B] that he was a dog! I could just choke the s--t out of him!' This nurse asked the mother for further details of the statement made. Mother stated, 'That CNA told [Resident B] that he eats so fast he is like a dog who is thrown a piece of bologna. I am going to make him pay for all the pain et troubles he has caused [Resident B]...!' This nurse told mother that the issue could be reported to weekend manager et would relay message that mother would like to talk to manager. CNA wrote down statement of what was said to [Resident B] the night before. Statement given to weekend manager."</p> <p>On 4/10/14 at 11:05 A.M., during interview with the Social Services Director (SSD), she indicated Resident B's mother reported to RN # 1 that CNA # 1 called Resident B a dog, then said Resident B ate like a dog. The SSD indicated CNA # 1 was not talking to Resident B, but that apparently 2 visitors in the resident's room asked the CNA how the resident was eating. The SSD indicated the friends must have informed the resident's mother of the comment. The SSD indicated it was a bad analogy and was inconsiderate, but that she didn't consider it abuse. The SSD indicated RN # 1 called in the Admissions Coordinator, who was the weekend manager, who came in and spoke with the resident's mother. She indicated the staff was inserviced on communication skills.</p> <p>At that time, the SSD provided</p>		<p>allegations of abuse to determine if the incidents are valid. Appropriate corrective action will be taken as needed. Staff have been re-educated on the policy and procedure of resident abuse. Staff have been re-educate on the policy and procedure on reporting verbal abuse. Reports filed with the ISDH will be reviewed during monthly QAPI meetings. This will be ongoing.</p>	

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	<p>documentation, which included the following statement from the Admissions Coordinator: "3/16/14 @ 4:00 p [RN # 1] brought to my attention a concern re: [Resident B] per his mother & that she would like to speak to weekend manager. I went down to unit and spent over 1 hr speaking with her regarding her concern. She stated [CNA # 1] called her son a 'dog.' She then went on to say that he made a reference comparing her son to a dog. She stated that she was told by friends visiting [Resident B] what was said. The visitors stated to mother that they asked about [Resident B's] eating & how he was doing since being released from speech therapy. I spoke to [CNA # 1] regarding the conversation at which time he wrote me a statement...I met with staff on skilled & inserviced them on tone, conversations, manners, & 'joking' with residents, staff, families, visitors. I immediately switched the CNA's [sic] to where [CNA # 1] would not be caring for [Resident B] rest of shift & asked [RN # 1] to document any other issues/conversations. Once I completed inservice, I called ED [Administrator] & informed him of concern, as well as actions taken to resolve it."</p> <p>On 4/10/14 at 11:30 A.M., the Admissions Coordinator was interviewed. She indicated she was the weekend manager working on March 16, 2013. She indicated RN # 1 called her and told her Resident B's mother was upset and wanted to talk to her. The Admissions Coordinator indicated the resident's mother told her, "That CNA called [Resident B] a dog." She then indicated the mother said the CNA "compared [Resident B] to a dog." The Admissions Coordinator indicated the mother had multiple complaints. She indicated the resident had 2 friends</p>			

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F000271 SS=D	<p>visiting in his room, and the visitors asked CNA # 1 how the resident was eating. The CNA indicated, "It's like a dog going after bologna," because the resident ate so quickly. The Admissions Coordinator indicated the mother was not present, but the visitors or the resident must have called the mother. The Admissions Coordinator indicated she inserviced staff, and told CNA # 1 to stay out of the resident's room. She indicated she informed the Administrator of the situation, but did not consider it an abuse situation.</p> <p>On 4/10/14 at 2:00 P.M., during interview with the Administrator, he indicated he did not report the allegation to the ISDH, because he did not think it was abuse. He indicated the Admissions Coordinator had called him that day and informed him of the concern and how she had handled it.</p> <p>2. On 4/8/14 at 9:40 A.M., the Administrator provided the current facility policy on "Prevention and Reporting: Resident Mistreatment, Neglect, Abuse..." revised April 2013. The policy included: "...All allegations that meet the definition of abuse and substantiated violations will be reported to state agencies...as required...Verbal abuse is oral, written, or gestured language that includes disparaging and derogatory terms to the resident or their families or within their hearing distance regardless of their age, ability to comprehend or disability...."</p> <p>This Federal tag relates to Complaint IN00146067.</p> <p>3.1-28(a) 483.20(a) ADMISSION PHYSICIAN ORDERS FOR</p>			

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	<p>IMMEDIATE CARE</p> <p>At the time each resident is admitted, the facility must have physician orders for the resident's immediate care.</p> <p>Based on interview and record review, the facility failed to ensure a resident's primary physician was notified of a resident's admission to the facility, and transfer orders from the hospital were approved by the physician, for 1 of 3 residents reviewed with admission orders, in a sample of 10. Resident E</p> <p>1. The clinical record of Resident E was reviewed on 4/8/14 at 11:10 A.M. Diagnoses included, but were not limited to, atrial fibrillation.</p> <p>The resident was admitted to the facility on 3/19/14. Physician orders transcribed by LPN # 1 included: "Heparin 5000 U/ml, Inject 1 ml SQ [subcutaneously] BID [twice daily]," and "Warfarin [Coumadin, a blood thinner] 2.5 mg QD [every day], Warfarin 5 mg QD."</p> <p>A physician's order for lab work to monitor the Coumadin levels was not found in the clinical record.</p> <p>A physician's order, dated 3/28/14, indicated: "1. Any communication re: care of res [resident] must go though [sic] Triage. 2. All orders written @ fac [facility] must be faxed to Triage. 3. Please mark chart/MAR [medication administration record] as appropriate for compliance [with] orders 1 [and] 2...5. PT/INR [lab to monitor Coumadin] stat [immediately] today...."</p> <p>On 4/9/14 at 9:40 A.M., during interview with</p>	F000271	F 271 The physician orders for resident E have been clarified. The physician for resident E was aware of this patient's admission due to a clarification order given as noted on the physician order statement. The NP was on vacation at time of admission of the resident. The physician notified for clarification was the medical director. An audit was conducted on residents admitted in the last 30 days to ensure the physicians were notified of the admission and orders clarified. Physician notification and order clarification is indicated by the audit tool. Licensed staff was educated on notifying physicians on new admissions and clarifying physician orders on new admissions. The charts of new admissions will be audited to ensure physician notification and clarification of physician orders. DON/Designee will review the audit 5 X weekly on new admissions to ensure physician notification and physician orders are clarified. Results of the audits are reviewed during monthly QAPI. This will be ongoing.	05/10/2014

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	<p>the Director of Nursing (DON), she indicated a Coumadin audit was done monthly. It was during this audit that it was discovered Resident E did not have a Coumadin log, and therefore, had not had PT/INRs drawn. The DON indicated the nurse should have called the attending physician to receive approval of the transfer orders from the hospital.</p> <p>On 4/9/14 at 10:15 A.M., during interview with LPN # 1, she indicated she received the admission orders from the Assistant Director of Nursing (ADON). She indicated the ADON usually would write out the transfer orders on a facility physician order document, but the ADON gave them to her. LPN # 1 indicated she mistakenly faxed the hospital orders to triage, instead of the facility physician orders. LPN # 1 indicated the DON had informed her of her mistake.</p> <p>On 4/9/14 at 2:30 P.M., the Nurse Practionner for Resident E was interviewed. She indicated, "The resident was on Heparin and Coumadin, and no lab work had been ordered, so I ordered a stat PT/INR." The Nurse Practionner indicated, "We didn't even know he was here."</p> <p>2. On 4/10/14 at 8:50 A.M., the Director of Nursing provided the current facility policy on "Admission Orders," dated January 2012. The policy included: "Admission orders will be obtained/approved through the attending Physician as soon as possible following or prior to the resident admission to the center. If the attending Physician or their alternate cannot be reached, the center shall contact the Medical Director for receipt of temporary orders...."</p> <p>This Federal tag relates to Complaint</p>			

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F000329 SS=D	<p>IN00146820.</p> <p>3.1-30(a) 483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS</p> <p>Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>Based on interview and record review, the facility failed to ensure adequate monitoring for a resident receiving Coumadin and Heparin, in that no lab was ordered for 9 days, for 1 of 3 residents reviewed who received Coumadin, in a sample of 10. Resident E</p> <p>Findings include:</p> <p>1. On 4/8/14 at 9:40 A.M., the Director of Nursing (DON) provided a document</p>	F000329	F 329 Resident E's physician ordered pt/inrs to ensure the resident is within therapeutic range which is high due to his multiple diagnoses of fracture hip, dialysis, and afib. Licensed staff was educated on obtaining pt/inr orders when a resident is on Coumadin/Heparin. These residents will have a tracking log in place. An audit was completed to ensure all residents on Coumadin have a tracking log in	05/10/2014

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	<p>indicating which residents received Coumadin. Resident E was listed as one of those residents.</p> <p>The clinical record of Resident E was reviewed on 4/8/14 at 11:10 A.M. Diagnoses included, but were not limited to, atrial fibrillation.</p> <p>The resident was admitted to the facility on 3/19/14. Physician orders transcribed by LPN # 1 indicated: "Heparin 5000 U/ml, Inject 1 ml SQ [subcutaneously] BID [twice daily]," and "Warfarin [Coumadin, a blood thinner] 2.5 mg QD [every day], Warfarin 5 mg QD."</p> <p>A physician's order for lab work to monitor the Coumadin levels was not found in the clinical record.</p> <p>A physician's order, dated 3/28/14, indicated: "1. Any communication re: care of res [resident] must go through [sic] Triage. 2. All orders written @ fac [facility] must be faxed to Triage. 3. Please mark chart/MAR [medication administration record] as appropriate for compliance [with] orders 1 [and] 2...5. PT/INR [lab to monitor Coumadin] stat [immediately] today...."</p> <p>A Protime [PT]/INR, dated 3/28/14 at 4:05 P.M., indicated: Protime H [high] 24.2 [normal 9.4-11.4], INR H 2.3 [normal 0.9-1.1]."</p> <p>A Physician's order, dated 3/28/14, indicated: "D/C [discontinue] heparin. Con [continue] current dose Coumadin. Coumadin 7.5 mg po QD. Re check PT/INR in 2 weeks 4-11-14."</p> <p>A "Coumadin (PT/INR) Log," dated 3/28/14, indicated: "[Normal] INR Ranges: 2.0-3.0 =</p>		<p>place as well as labs ordered. Re-education was completed with licensed nursing staff to ensure understanding of labs being done appropriately and logs filled out. An audit is completed weekly to ensure residents on Coumadin have labs ordered and logs are in place to ensure the resident's are within therapeutic range. DON/Designee will review the audits 5 X weekly for 6 months to ensure residents on Coumadin have labs ordered and logs are in place. Results of the audits are reviewed during monthly QAPI further recommendations</p>	

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	<p>...A-Fib [atrial fibrillation]...MD Ordered PT/INR Range [blank], PT/INR [blank], Current Coumadin dose 7.5 mg, Reviewed Previous PT/INR [blank]...."</p> <p>On 4/9/14 at 9:40 A.M., during interview with the DON, she indicated a Coumadin audit is done monthly. It was during this audit that it was discovered Resident E did not have a Coumadin log, and therefore, had not PT/INRs drawn. The DON indicated the Nurse Practionner was "mad" about the lack of lab work, and ordered a stat PT/INR.</p> <p>On 4/9/14 at 2:30 P.M., the Nurse Practionner for Resident E was interviewed. She indicated, "The resident was on Heparin and Coumadin, and no lab work had been ordered, so I ordered a stat PT/INR." The Nurse Practionner indicated the lab work turned out to be "okay," but "it could have been very serious."</p> <p>2. On 4/10/14 at 8:50 A.M., during interview with the Director of Nursing, she indicated the facility did not have a particular policy regarding the administration of Coumadin. She provided a "Clinical Systems Audit-Coumadin Quality Assurance Review" document, which she indicated was completed monthly. The audit included: "Current medication order reflects dose, route, frequency...Medication box reflects current order; Current MD orders include order for PT/INR no less than monthly; Most recent lab results are on chart with MD notification documented timely...."</p> <p>This Federal tag relates to Complaint IN00146820.</p> <p>3.1-48(a)(3)</p>			

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F000514 SS=D	<p>483.75(l)(1) RES RECORDS-COMplete/ACCURATE/ACCE SSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>Based on interview and record review, the facility failed to ensure the correct hospital transfer orders were in a resident's clinical record, for 1 of 3 residents reviewed for accurate and complete transfer orders, in a sample of 10. Resident E</p> <p>The clinical record of Resident E was reviewed on 4/8/14 at 11:10 A.M. Diagnoses included, but were not limited to, atrial fibrillation.</p> <p>The resident was admitted to the facility on 3/19/14. Hospital transfer orders, marked with a notation "d/c [discharge] packet copy," included: "As of 3/18/14, 3:20 PM, START taking these medications: Heparin 5000 Unit/ml injection...2 times daily...STOP taking these medications, Warfarin 5 mg tablet Commonly known as Coumadin...."</p> <p>Additional hospital records in the clinical record included: "Medication List - Snapshot, As of 3/19/2014, 2:57 P.M., CHANGE how</p>	F000514	F 514 Transfer orders from the hospital are in place for resident E. The hospital records that were received include many duplicates. Different physician's sent records pertaining to different comorbidities as indicated. The records were placed in the misc. section for physician and nurse's review as needed. These orders include a snapshot of medications taken at different times during the hospitalization. These snapshot records are not transfer orders and are not meant to take the place of transfer orders. An audit was conducted on residents admitted in the last month to ensure the correct hospital transfer orders were on the residents chart. Correct hospital transfer orders were placed on the residents chart if indicated by the audit. Re-education was completed with	05/10/2014

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	<p>you take these medications, Warfarin 5 mg tablet Commonly known as Coumadin...Warfarin 2.5 mg tablet..." An order for heparin was not included in these orders.</p> <p>Physician orders transcribed by LPN # 1 included: "Heparin 5000 U/ml, Inject 1 ml SQ [subcutaneously] BID [twice daily]," and "Warfarin [Coumadin, a blood thinner] 2.5 mg QD [every day], Warfarin 5 mg QD."</p> <p>A physician's order, dated 3/28/14, indicated: "1. Any communication re: care of res [resident] must go though [sic] Triage. 2. All orders written @ fac [facility] must be faxed to Triage. 3. Please mark chart/MAR [medication administration record] as appropriate for compliance [with] orders 1 [and] 2...5. PT/INR [lab to monitor Coumadin] stat [immediately] today...."</p> <p>On 4/8/14 at 2:00 P.M., during interview with the Director of Nursing (DON), she indicated the nurse should have taken the newer transfer orders, but that the "Snapshot" orders should not be used. The DON indicated the hospital sends so many documents, and is not always consistent in what they send to the facility. The DON indicated she wondered if the nurse "took off orders from both sets of orders."</p> <p>On 4/9/14 at 9:40 A.M., during interview with the DON, she indicated she spoke with LPN # 1, who transcribed the orders. The DON indicated LPN # 1 indicated the current discharge orders in the chart were not what she had originally seen. The DON indicated they "tracked down" the discharge orders, by contacting the hospital. The DON indicated she did not know where the original hospital</p>		<p>licensed nursing staff to ensure the correct transfer orders are put on the residents chart and that only records pertinent to the record will be placed on the chart-chest x-ray, h&p, new orders, ECT. Duplicate and hospital medical records on newly admitted residents will no longer be included in the residents chart. They will be placed in a separate envelope and be made available as needed. Audits on the charts of new admissions will be completed to ensure the correct transfer orders are put on the residents chart. DON/Designee will review the audit sheets 5 X weekly for 6 months to ensure the correct transfer orders are put on the residents chart. Results of the audits are reviewed during monthly QAPI for recommendations.</p>	

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	<p>discharge records were. The DON provided at that time discharge orders which included: "Medications, As of 3/19/14 at 1:40 P.M., START taking these medications...heparin...CHANGE how you take these medications, Warfarin 2.5 mg...Warfarin 5 mg...."</p> <p>On 4/9/14 at 10:15 A.M., during interview with LPN # 1, she indicated she received the admission orders from the Assistant Director of Nursing (ADON). She indicated the ADON usually would write out the transfer orders on a facility physician order document, but the ADON gave them to her. LPN # 1 indicated, "Then the resident came, and a packet of information came with him." LPN # 1 indicated she thought that a lot of the documents were duplicates, and must have thrown the correct ones away.</p> <p>This Federal tag relates to Complaint IN00146820.</p> <p>3.1-50(a)(1) 3.1-50(a)(2)</p>			