

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155064	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  07/17/2015
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NAME OF PROVIDER OR SUPPLIER  APERION CARE KOKOMO	STREET ADDRESS, CITY, STATE, ZIP CODE 3518 S LAFOUNTAIN ST KOKOMO, IN 46902
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F 0000  Bldg. 00	<p>This visit was for the Investigation of Complaint #IN00177352.</p> <p>Complaint #IN00177352- Substantiated. Federal/State deficiencies related to the allegations are cited at F157, F282, F323 and F329.</p> <p>Survey dates: July 14, 15, 16, &amp; 17, 2015</p> <p>Facility number: 000025 Provider number: 155064 AIM number: 100274850</p> <p>Census bed type: SNF- 7 SNF/NF- 49 Total- 56</p> <p>Census payor type: Medicare- 7 Medicaid- 41 Other- 8 Total- 56</p> <p>Sample: 9</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1.</p>	F 0000		

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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F 0157 SS=G Bldg. 00	<p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>Based on interviews and record reviews, the facility failed to provide physician notification, appropriately, for</p>	F 0157	<b>F 157 The facility requests paper compliance for this citation.</b> The filing of this plan of correction does not constitute	07/28/2015	

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	<p>clarification related to the need for lab orders for a resident on chronic anticoagulant therapy. Resident B had an INR of 10.25 (critical bleeding time), sustained a fall with a resulting brain bleed and was hospitalized. (Resident B) The facility also failed to notify the physician timely for lab results and weight gain for a resident with congestive heart failure, in a timely manner, (Resident F) for 2 of 4 residents reviewed for physician notification, in a sample of 11.</p> <p>Findings include:</p> <p>1.) The clinical record for Resident B was reviewed on 7/14/15 at 11:00 a.m. Diagnoses for Resident B included, but were not limited to, congestive heart failure, atrial fibrillation, chronic use of anticoagulants because of atrial fibrillation, high blood pressure and renal insufficiency.</p> <p>Physician orders for Resident B, dated 2/02/15, indicated PT/INR (bleeding time, prothrombin time/international normalized ratio) one time a day, every Tuesday. Physician orders, dated 3/10/15, indicated INR, one time only for Coumadin (an anticoagulant, used to prevent blood from clotting, Warfarin is generic form) therapy for 1 day, do on</p>		<p>an admission that the alleged deficiency exists. This plan of correction is provided as evidence of the facility's desire to comply with the regulations and to continue to provide quality care. <b>(1) Immediate actions taken for those residents identified:</b> 1. Resident # B &amp; F No longer resides in this facility.</p> <p><b>(2) How the facility identified other residents:</b> A 100% audit of all residents receiving Anticoagulation therapy have PT/INR orders on 7/17/15 A 100% audit of all residents with the diagnosis of CHF have been reviewed for protocols on weight changes was completed on 7/28/15. <b>(3) Measures put into place / System Changes:</b> Anticoagulation orders will be reviewed 5 days a week for PT/INR orders. Labs will be reviewed 3 days a week for PT/INR results and nurses will be notified of omissions for physician notification. Weights will be reviewed 3 days a week for physician notification on weight changes and nurses will be notified of omissions. Nurses received education on obtaining orders for weights on residents with CHF, writing anticoagulation order, obtaining Lab Orders for PT/INR's, and timely notification to physicians. Nurses will be educated thru In-Services.</p> <p><b>(4) How the corrective actions will be monitored:</b> The DON/Designee will audit</p>				

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	<p>3/10/15.</p> <p>Nursing notes indicated Resident B went to the hospital for a procedure on 2/24/15. Hospital notes indicated Resident B had a left and right heart catheterization and a coronary angiogram on 2/24/15. Hospital discharge instructions for admission to the facility, dated 2/25/15, indicated an order for Warfarin (an anticoagulant) 5 milligrams (mg), one tablet daily. Lab orders for PT/INR were not included on the discharge instructions.</p> <p>Nurses notes, indicated the following: 3/13/15 at 6:00 a.m., "writer was getting report from night nurse when writer noticed [Resident B] standing in doorway. [Resident B] started to fall forward but twisted around and landed on his back, head bouncing off the floor, [Resident B] was knocked unconscious for a few seconds, back of head bleeding. [Resident B] confused. 911 called, vital signs obtained, within normal limits. Son notified at 6:20 a.m. and MD [physician] notified at 6:25 a.m., report called to ER [emergency room] at 6:28 a.m."</p> <p>3/13/15 at 8:05 a.m., "[name of hospital] ER called, gave report to writer, sending [Resident B] back [to facility], CT normal, Cervical spine x-ray normal,</p>		<p>anticoagulants for lab orders 3 X a week and present findings in Q.A. monthly X 3 months. The DON/Designee will audit 24 hour progress note summary for physician notification 3 X a week and present findings in Q.A. monthly X 3 months. The DON/Designee will audit resident weights 3 X a week and present findings in Q.A. monthly X 3 months. <b>(5) Date of Compliance:</b> 7/28/15</p>		

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	<p>glued laceration on back of head d/t [due to] huge hematoma, resident sleepy."</p> <p>3/13/15 at 8:15 a.m., "[Resident B] back from ER head still bleeding, Writer called MD to see if we can get STAT [immediate] labs, MD ordered PT/INR, CBC, BMP and UA."</p> <p>3/13/15 9:30 a.m., "[Resident B's] head in back very swollen, neuro checks continue resident alert, opens eye spontaneously when spoken to, answers questions appropriately, vital signs obtained, voices no complaints at this time, will continue to monitor."</p> <p>3/13/15 at 12:30 p.m., "STAT PT/INR results INR 10.5, PT 127 seconds. [Resident B] stating nausea and is more confused. MD made aware. 911 called. EMTs [emergency medical technician] arrived. [Resident B] taken to ER."</p> <p>3/13/15 at 4:47 p.m., "[name of hospital] ER nurse called, said Resident B had another CT scan done, he has a massive brain bleed and is being sent to [name of hospital] for emergency surgery."</p> <p>Lab results for Resident B, dated 3/13/15, specimen collected at 10:30 a.m., indicated critical results related to the length of time it takes for blood to clot. A</p>			

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	<p>prolonged PT means that the blood is taking too long to form a clot. The following results were listed:                      Protime- indicated "H" (high) greater than 120.0 (normal limits: 8.9 - 11.5)                      INR- indicated "Critical result noted" 10.25 (seconds) (normal limits: 2.0 - 3.0)</p> <p>During an interview, on 7/17/15 at 10:40 a.m., the interim Director of Nursing indicated residents with anticoagulant orders, such as Coumadin (generic form is Warfarin), usually have lab orders for PT/INR. If there aren't any lab orders, the nurse should contact the physician for clarification. In this case, the physician was not notified for clarification.</p> <p>2.) The clinical record for Resident F was reviewed on 7/16/15 at 9:40 a.m. Diagnoses for Resident F included, but were not limited to, atrial fibrillation, congestive heart failure, cardiac pacemaker in situ, history of cerebrovascular accident, and high blood pressure.</p> <p>a.) Nurses notes, dated 5/7/15 at 3:29 p.m., indicated: "New order received to change Coumadin dose and recheck INR in 1 week [5/14/15]. Message left for [name of family member] and pharmacy notified and lab ordered."</p>			

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	<p>Lab results, dated 5/14/15, indicated the following results were reported to facility staff on 5/14/15 at 5:00 p.m.</p> <p>PT- 12.8, indicated "H" (high) (normal limits: 9.5 - 11.8)</p> <p>INR- 1.2, indicated "H" (high) (normal limits: 0.9 - 1.1)</p> <p>Documentation indicated the physician was notified of the high results on 5/18/15, 4 days after they were reported to the facility.</p> <p>Resident F's care plan for anticoagulant therapy, related to the diagnoses of atrial fibrillation, dated 4/28/15, included the following interventions:</p> <p>Administer anticoagulant medications as ordered by physician. Monitor for side effects and effectiveness every shift. Labs as ordered. Report abnormal lab results to the MD.</p> <p>The DON indicated, during an interview on 7/17/15 at 1:20 p.m., the lab order was collected on 5/14/15, however, there was not documentation to indicate when the results were communicated with the physician until 5/18/15. Lab results, especially abnormal values, were expected to be communicated with the physician as soon as the results were communicated with the attending nurse.</p>			

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	<p>b.) The following weights were documented for Resident F:</p> <p>4/28/15 165.8 4/30/15 171.8 5/09/15 181.0</p> <p>On 5/15/15 at 10:45 p.m., nurses notes indicated Resident F "had gained 16 pounds in two weeks, bilateral lower extremities had +3 edema, lungs sounded congested, and the family was worried because Resident F was not on Lasix [diuretic]. MD notified of changes and family concerns. New orders for Lasix, increase in Potassium, and weigh daily."</p> <p>A care plan for Congestive Heart Failure, dated 4/28/15 included the following interventions:</p> <ul style="list-style-type: none"> <li>- Monitor weight as ordered.</li> <li>- Monitor/document/report, signs and symptoms of Congestive Heart Failure: dependent edema of legs and feet, periorbital edema, shortness of breath upon exertion, cool skin, dry cough, distended neck veins, weakness, weight gain unrelated to intake, crackles and wheezes upon auscultation of the lungs, orthopnea, weakness and/or fatigue, increased heart rate (tachycardia) lethargy and disorientation.</li> </ul> <p>During an interview, on 7/17/15 at 1:20</p>			

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F 0282 SS=D Bldg. 00	<p>p.m., the DON indicated daily weight increases of two or more pounds were expected to be shared with the physician, especially for residents with a diagnosis of congestive heart failure. She did not know why Resident F's weight gains were not communicated to the physician until 5/15/15. Nurses were expected to provide such notification as soon as possible.</p> <p>3.1-5(2) 3.1-5(3)</p> <p>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.</p> <p>Based on record review and interview, the facility failed to follow care plans for congestive heart failure and anticoagulant therapy for 1 of 11 residents reviewed for care plans. (Resident F).</p> <p>Findings include:</p> <p>The clinical record for Resident F was reviewed on 7/16/15 at 9:40 a.m. Diagnoses for Resident F included, but were not limited to, atrial fibrillation, congestive heart failure, cardiac pacemaker in situ, history of</p>	F 0282	<p><b>F 282 The facility requests paper compliance for this citation.</b> The filing of this plan of correction does not constitute an admission that the alleged deficiency exists. This plan of correction is provided as evidence of the facility's desire to comply with the regulations and to continue to provide quality care. <b>(1) Immediate actions taken for those residents identified:</b> 1. Resident # F No longer resides in this facility. <b>(2) How the facility identified other residents:</b> A 100% audit of all residents receiving Anticoagulation therapy have</p>	07/28/2015			

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	<p>cerebrovascular accident, and high blood pressure.</p> <p>a.) Nurses notes, dated 5/7/15 at 3:29 p.m., indicated: New order received to change Coumadin dose and recheck INR in 1 week (5/14/15). Message left for (name of family member) and pharmacy notified and lab ordered.</p> <p>Lab results, dated 5/14/15, indicated the following results were reported to facility staff on 5/14/15 at 5:00 p.m. PT- 12.8, indicated "H" (high) (normal limits: 9.5 - 11.8) INR- 1.2, indicated "H" (high) (normal limits: 0.9 - 1.1)</p> <p>Documentation indicated the physician was notified of the high results on 5/18/15.</p> <p>A care plan for anticoagulant therapy related to the diagnoses of atrial fibrillation, dated 4/28/15, included the following interventions:</p> <ul style="list-style-type: none"> <li>- Administer anticoagulant medications as ordered by physician. Monitor for side effects and effectiveness every shift.</li> <li>- Labs as ordered. Report abnormal lab results to the MD.</li> </ul> <p>The DON indicated, during an interview on 7/17/15 at 1:20 p.m., the lab order was</p>		<p>PT/INR orders on 7/17/15 A 100% audit of all residents with the diagnosis of CHF have been reviewed for protocols on weight changes and care plans updated as needed was completed on 7/28/15. <b>(3) Measures put into place / System Changes:</b> Labs will be reviewed 3 days a week for PT/INR results and nurses will be notified of omissions for physician notification. Weights will be reviewed 3 days a week for physician notification on weight changes and nurses will be notified of omissions. Nurses received education on obtaining orders for weights on residents with CHF and timely notification to physicians on lab results. All nurses will be educated thru In-Services. <b>(4) How the corrective actions will be monitored:</b> The DON/Designee will audit 24 hour progress note summary for physician notification of lab results 3 X a week and present findings in Q.A. monthly X 3 months. The DON/Designee will audit resident weights 3 X a week and present findings in Q.A. monthly X 3 months. <b>(5) Date of Compliance:</b> 7/28/15</p>		

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	<p>collected on 5/14/15, however, there was not documentation to indicate when the results were communicated with the physician until 5/18/15. Lab results, especially abnormal values, were expected to be communicated with the physician as soon as the results were communicated with the attending nurse.</p> <p>b.) The following weights were documented for Resident F: 4/28/15 165.8 4/30/15 171.8 5/09/15 181.0</p> <p>A care plan for Congestive Heart Failure, dated 4/28/15 included the following interventions: - Monitor weight as ordered. - Monitor/document/report, signs and symptoms of Congestive Heart Failure: dependent edema of legs and feet, periorbital edema, shortness of breath upon exertion, cool skin, dry cough, distended neck veins, weakness, weight gain unrelated to intake, crackles and wheezes upon auscultation of the lungs, orthopnea, weakness and/or fatigue, increased heart rate (tachycardia) lethargy and disorientation.</p> <p>On 5/15/15 at 10:45 p.m., nurses notes indicated Resident F had gained 16 pounds in two weeks, bilateral lower</p>			

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F 0323 SS=D Bldg. 00	<p>extremities had +3 edema, lungs sounded congested, and the family was worried because Resident F was not on Lasix (diuretic). MD notified of changes and family concerns. New orders for Lasix, increase in potassium, and weigh daily.</p> <p>During an interview, on 7/17/15 at 1:20 p.m., the DON indicated daily weight increases of two or more pounds were expected to be shared with the physician, especially for residents with a diagnosis of congestive heart failure. She did not know why Resident F's weight gains were not communicated to the physician until 5/15/15. Nurses were expected to provide such notification as soon as possible.</p> <p>3.1-35(g)(2) 483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observations and interview, the facility staff failed to ensure safety was maintained during 2 of 2 observations of transfers using a mechanical lift. (Residents K &amp; L)  Findings include:</p>	F 0323	<p><b>F 323 The facility requests paper compliance for this citation.</b> The filing of this plan of correction does not constitute an admission that the alleged deficiency exists. This plan of correction is provided as evidence of the facility's desire to</p>	07/28/2015			

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	<p>1.) During an observation on 7/14/15 at 11:55 a.m., CNA #1 and CNA #2 transferred Resident K from her bed to her wheelchair, using a Sara Lift 3000, sit to stand lift. Prior to securing Resident K with the transfer sling, the CNA's did not ensure the lift brakes were locked. During the actual movement from a sitting position to a standing position, CNA #1 physically placed her left foot next to the left spreader bar to prevent further rolling or movement. The brakes remained unlocked for the remainder of the transfer as Resident K was lowered to her wheelchair. During the observation, Resident K's wheelchair brakes were not locked, either, as Resident K was lowered into her wheelchair.</p> <p>2.) On 7/14/15 at 12:30 p.m., during an observation, Resident L was transferred via a total mechanical lift, from his bed to his wheelchair by CNA #1 and CNA #3. Prior to securing Resident L with the transfer sling, the CNA's did not ensure the total mechanical lift brakes were locked. During the transfer from his bed, CNA #3 physically placed her right foot next to the spreader bar to prevent further rolling or movement. The brakes remained unlocked for the remainder of the transfer as Resident L was lowered into his wheelchair. Additionally, it was</p>		<p>comply with the regulations and to continue to provide quality care. <b>(1) Immediate actions taken for those residents identified:</b> Resident # K received no injury related transfer with the Sara Lift 3000 Resident #L received no injury related transfer with the Mechanical Lift. CNA # 1 &amp; 2 received education on locking the wheels of the Sara Lift 3000 and locking The wheelchair brakes during a transfer. CNA # 1 &amp; 3 received education on locking the wheels of the Mechanical Lift and locking The wheelchair brakes during a transfer. <b>(2) How the facility identified other residents:</b> Transfer modalities were reviewed for all residents, for safety and appropriateness 7/28/15. <b>(3) Measures put into place / System Changes:</b> New employees will received training on the use and safety of mechanical lift during orientation. CNA's will complete a competency observation quarterly on the Sara Lift 3000 and the Total Mechanical Lift to assure proper safety techniques are utilized. CNA's received education regarding safety guidelines on use of the Sara Lift 3000 and Mechanical Lift and a return demonstration was completed. <b>(4) How the corrective actions will be monitored:</b> The DON/Designee will complete</p>				

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	<p>noted, Resident L's wheelchair brakes were not locked as Resident L was lowered into his wheelchair.</p> <p>During an interview with the DON on 7/14/15 at 2:15 p.m., she indicated the brakes should have been locked when each lift was not in motion and the wheelchair brakes should have been locked, too.</p> <p>Facility guidelines, titled "Transfers/Positioning Stand Assist Lift", dated 6/2012, and submitted by the DON on 7/14/15 at 2:15 p.m., indicated: "...5. When the resident is in a standing position and stable, unlock the brake, bring the spreader bar base together to narrow the base to allow for ease of transfer. 6. Transfer the resident carefully, reassuring them as you transfer. Place them over the surface of the chair, toilet, etc. Lock the brakes and, when possible, widen the spreader bar for stability...."</p> <p>Facility guidelines, titled "Transfer/Positioning - Total Mechanical Lift", dated 6/12, and submitted by the DON on 7/14/15 at 2:15 p.m., indicated: "...7...locking brakes ensure safety during the lifting procedure... Always lock the brakes during transfer for safety ...Procedure: ...6... Move the lift into</p>		<p>competencies on 3 CNA's each week and present findings in Q.A. monthly X 3 months. (5) <b>Date of Compliance:</b> 7/28/15</p>				

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F 0329 SS=G Bldg. 00	<p>place under the bed frame. Spread the base and lock in place...9...Lock the brakes before lowering the resident...."</p> <p>3.1-45(a)(1) 3.1-45(a)(2)</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> <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 interviews, the facility failed to provide anticoagulant monitoring, appropriately, for 2 of 4 residents reviewed for anticoagulant therapy in a sample of 11. (Resident B and F) Resident B did not have bleeding</p>	F 0329	<b>F 329 The facility requests paper compliance for this citation.</b> The filing of this plan of correction does not constitute an admission that the alleged deficiency exists. This plan of correction is provided as evidence of the facility's desire to	07/28/2015

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	<p>labs drawn timely, sustained a fall resulting in a brain bleed and had a subsequent INR level of 10.25 (bleeding time) after the fall.</p> <p>Findings include:</p> <p>1.) The clinical record for Resident B was reviewed on 7/14/15 at 11:00 a.m. Diagnoses for Resident B included, but were not limited to, congestive heart failure, atrial fibrillation, chronic use of anticoagulants because of atrial fibrillation, high blood pressure and renal insufficiency.</p> <p>Physician orders for Resident B, dated 2/02/15, indicated PT/INR (bleeding time, prothrombin time/international normalized ratio) one time a day, every Tuesday. Physician orders, dated 3/10/15, indicated INR, one time only for Coumadin (an anticoagulant, used to prevent blood from clotting, Warfarin is generic form) therapy for 1 day, do on 3/10/15.</p> <p>Nursing notes indicated Resident B went to the hospital for a procedure on 2/24/15. Hospital notes indicated Resident B had a left and right heart catheterization and a coronary angiogram on 2/24/15. Hospital discharge instructions for admission to the facility,</p>		<p>comply with the regulations and to continue to provide quality care. <b>(1) Immediate actions taken for those residents identified:</b> 1. Resident # B &amp; F No longer resides in this facility.</p> <p><b>(2) How the facility identified other residents:</b> A 100% audit of all residents receiving Anticoagulation therapy have PT/INR orders and timely physician notification on 7/17/15.</p> <p><b>(3) Measures put into place / System Changes:</b> Anticoagulation orders will be reviewed 3 days a week for PT/INR orders. Labs will be reviewed 3 days a week for PT/INR results and nurses will be notified of omissions for physician notification. Nurses received education on timely notification to physicians on lab results and documentation. All nurses will be educated thru In-Services.</p> <p><b>(4) How the corrective actions will be monitored:</b> The DON/Designee will audit 24 hour progress note summary for physician notification of lab results 3 X a week and present findings in Q.A. monthly X 3 months. <b>(5) Date of Compliance:</b> 7/28/15</p>	

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	<p>dated 2/25/15, indicated an order for Warfarin (an anticoagulant) 5 milligrams (mg), one tablet daily. Lab orders for PT/INR were not included on the discharge instructions.</p> <p>Nurses notes, indicated the following: 3/13/15 at 6:00 a.m., "writer was getting report from night nurse when writer noticed [Resident B] standing in doorway. [Resident B] started to fall forward but twisted around and landed on his back, head bouncing off the floor, [Resident B] was knocked unconscious for a few seconds, back of head bleeding. [Resident B] confused. 911 called, vital signs obtained, within normal limits. Son notified at 6:20 a.m. and MD [physician] notified at 6:25 a.m., report called to ER [emergency room] at 6:28 a.m."</p> <p>3/13/15 at 8:05 a.m., "[name of hospital] ER called, gave report to writer, sending Resident B back [to facility], CT normal, Cervical spine x-ray normal, glued laceration on back of head d/t [due to] huge hematoma, resident sleepy."</p> <p>3/13/15 at 8:15 a.m., "[Resident B] back from ER head still bleeding, Writer called MD to see if we can get STAT [immediate] labs, MD ordered PT/INR, CBC, BMP and UA."</p>			

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	<p>3/13/15 9:30 a.m., "[Resident B's] head in back very swollen, neuro checks continue resident alert, opens eye spontaneously when spoken to, answers questions appropriately, vital signs obtained, voices no complaints at this time, will continue to monitor."</p> <p>3/13/15 at 12:30 p.m., "STAT PT/INR results INR 10.5, PT 127 seconds. [Resident B] stating nausea and is more confused. MD made aware. 911 called. EMTs [emergency medical technician] arrived. [Resident B] taken to ER."</p> <p>3/13/15 at 4:47 p.m., "[name of hospital] ER nurse called, said [Resident B] had another CT scan done, he has a massive brain bleed and is being sent to [name of hospital] for emergency surgery." Lab results for Resident B, dated 3/13/15, specimen collected at 10:30 a.m., indicated critical results related to the length of time it takes for blood to clot. A prolonged PT means that the blood is taking too long to form a clot. The following results were listed: Prottime- indicated "H" (high) greater than 120.0 (normal limits: 8.9 - 11.5) INR- indicated "Critical result noted" 10.25 (seconds) (normal limits: 2.0 - 3.0)</p> <p>During an interview, on 7/17/15 at 10:40 a.m., the interim Director of Nursing</p>			

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	<p>indicated residents with anticoagulant orders, such as Coumadin (generic form is Warfarin), usually have lab orders for PT/INR. If there aren't any lab orders, the nurse should contact the physician for clarification. In this case, the physician was not notified for clarification.</p> <p>2.) The clinical record for Resident F was reviewed on 7/16/15 at 9:40 a.m. Diagnoses for Resident F included, but were not limited to, atrial fibrillation, congestive heart failure, cardiac pacemaker in situ, history of cerebrovascular accident, and high blood pressure.</p> <p>a.) Nurses notes, dated 5/7/15 at 3:29 p.m., indicated: "New order received to change Coumadin dose and recheck INR in 1 week [5/14/15]. Message left for [name of family member] and pharmacy notified and lab ordered."</p> <p>Lab results, dated 5/14/15, indicated the following results were reported to facility staff on 5/14/15 at 5:00 p.m. PT- 12.8, indicated "H" (high) (normal limits: 9.5 - 11.8) INR- 1.2, indicated "H" (high) (normal limits: 0.9 - 1.1)</p> <p>Documentation indicated the physician was notified of the high results on</p>			

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	<p>5/18/15.</p> <p>Resident F's care plan for anticoagulant therapy, related to the diagnoses of atrial fibrillation, dated 4/28/15, included the following interventions:</p> <ul style="list-style-type: none"> <li>- Administer anticoagulant medications as ordered by physician. Monitor for side effects and effectiveness every shift.</li> <li>- Labs as ordered. Report abnormal lab results to the MD.</li> </ul> <p>The DON indicated, during an interview on 7/17/15 at 1:20 p.m., the lab order was collected on 5/14/15, however, there was not documentation to indicate when the results were communicated with the physician until 5/18/15. Lab results, especially abnormal values, were expected to be communicated with the physician as soon as the results were communicated with the attending nurse.</p> <p>3.1-48(a)(6) 3.1-48(c)(2)</p>			