

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/08/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155226	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 07/30/2014
NAME OF PROVIDER OR SUPPLIER NORTH CAPITOL NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2010 N CAPITOL AVE INDIANAPOLIS, IN 46202		
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F 000	<p>INITIAL COMMENTS</p> <p>This visit was for the Investigation of Complaints IN00152832 and IN00153141.</p> <p>This visit resulted in a partially extended survey - immediate jeopardy.</p> <p>Complaint IN00152832 substantiated, federal/state deficiency related to the allegation is cited at F 329.</p> <p>Complaint IN00153141 substantiated. No deficiencies related to the allegations are cited.</p> <p>Survey dates: July 28, 29, & 30, 2014</p> <p>Facility number: 000131 Provider number: 155226 AIM number: 100274910</p> <p>Survey team: Connie Landman RN-TC</p> <p>Census bed type: SNF/NF: 112 Total: 112</p> <p>Census payor type: Medicare: 16 Medicaid: 85 Other: 11 Total: 112</p> <p>Sample: 5 Supplemental sample: 5</p> <p>This deficiency reflects state findings cited in accordance with 410 IAC 16.2.</p>	F 000			

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 000	Continued From page 1	F 000			
F 329 SS=J	<p>Quality Review was completed by Tammy Alley RN on August 1, 2014.</p> <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>This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to obtain and monitor laboratory values for anticoagulation medications for 2 of 7 residents receiving anticoagulation medication (Warfarin) to</p>	F 329	Past noncompliance: no plan of correction required.		

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F 329	<p>Continued From page 2</p> <p>prevent too high levels which could result in excessive bleeding resulting in Immediate Jeopardy. (Residents B and G)</p> <p>The Immediate Jeopardy began on 6/12/14 when the first missed lab draw occurred. The Administrator and Director of Nursing Services were notified of the Immediate Jeopardy at 1:45 p.m., on 7/29/14. The Immediate Jeopardy was removed and the deficient practice corrected on 7/22/14, prior to the start of the survey and was therefore Past Noncompliance.</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. The record for Resident B was reviewed on 7/28/14 at 1:40 p.m. Her diagnoses included, but were not limited to, cerebrovascular accident, hyperlipidemia, depression, mitral stenosis, hypertension, atrial fibrillation, renal failure, and osteoarthritis. <p>A physician's order, dated 6/10/14 and noted to be open ended, indicated Resident B was to receive 5 mg (milligrams) of Warfarin once a day at 5:00 p.m. Another order, dated 6/10/14 and also noted to be open ended, indicated PT/INR (Prothrombin Time/International Normalized ratio - measuring blood clotting time) was to be done on Tuesdays and Thursdays, and the results called to the physician.</p> <p>A health care plan, dated 6/20/14, indicated a problem of Resident B being at risk for abnormal/excessive bleeding due to use of anticoagulant medication. Interventions included, but were not limited to, document abnormal findings and notify MD, Labs (laboratory tests) as ordered, and medications as ordered.</p>	F 329			

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F 329	Continued From page 3 The June and July, 2014, MARs (Medication Administration Records) indicated Resident B received Warfarin 5 mg every day from June 12, 2014, through July 14, 2014, except June 20, 2014, June 29, 2014, and July 4, 2014. The record lacked documentation of any PT/INR results except on 6/10/14, the date of Resident B's admission to the facility. On July 15, 2014, Resident B was sent to the hospital Emergency Department due to complaints of severe neck and back pain. A PT/INR done at the hospital on 7/16/14 indicated the levels were PT H (high) >140.0 sec (seconds) (normal range 8.4-12.9) and an INR C (critical) > 13.21 (normal range 0.9 1.22). During an interview with the DNS (Director of Nursing Services) and HFA (Health Facility Administrator) on 7/28/14 at 3:30 p.m., the DNS indicated "we messed up." She also indicated in June, 2014, the facility was beginning the conversion of physician orders to the (computer) Matrix System. She also indicated Resident B was one of the first they had done the conversion on, and the nurse had forgotten to notify the lab of the order for the PT/INR. 2. The record for Resident G was reviewed on 7/29/14 at 12:15 p.m. Her diagnoses included, but were not limited to chronic pain, venous thrombosis, hypertension, hypothyroidism, osteoarthritis, and venous insufficiency. A physician's order, dated 7/24/14, indicated Resident G was to receive Warfarin 5 mg every day. The previous order, dated 6/20/14, indicated	F 329			

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F 329	<p>Continued From page 4</p> <p>she was to receive Warfarin 3 mg every day. On 7/18/14, the order was changed to 4 mg every day.</p> <p>A physician's order, dated 5/19/14, indicated a PT/INR was to be done every Monday and Thursday until it reached a therapeutic level. On 7/18/14, the PT/INR order was for a PT/INR to be done daily.</p> <p>A health care plan, dated, 5/28/14, indicated Resident G was at risk for abnormal bleeding due to use of anticoagulant medications. Interventions included, but were not limited to, document abnormal findings and notify MD, labs as ordered, and medications as ordered.</p> <p>The record lacked PT/INR lab results after 6/19/14 until 7/18/14.</p> <p>During an interview with RN # 1 on 7/29/14 at 12:40 p.m., she indicated she could not find any PT/INR results between 6/19/14 and 7/18/14 that were not already in the record.</p> <p>During an interview with LPN # 2 on 7/29/14 at 12:45 p.m., she indicated Resident G was in the building during that time frame, and she did not know why the ordered PT/INR levels were not done.</p> <p>An undated current facility policy, provided by the DNS on 7/29/14 at 10:45 a.m., titled "Guidelines for Lab Tracking" indicated: "...Review MD orders and place in tracking binder at time order reviewed When ordering lab - fax order to lab, then place it in separate binder at nurse's station. When lab comes to draw lab - nurse to sign lab slip upon</p>	F 329			

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F 329	<p>Continued From page 5</p> <p>arrival and upon departure - put a copy of form with nurse's signature in the lab draw binder... ...When lab result comes in - notify MD of results - note date/time signature that lab was faxed to MD. NOTE: CRITICAL LABS SHOULD BE REPORTED BY TELEPHONE TO THE MD...."</p> <p>The past noncompliance immediate jeopardy began on 6/12/14. The immediate jeopardy was removed and the deficient practice corrected by 7/22/14 after the facility implemented a systemic plan that included the following practices: An audit of physician's orders and labs for residents receiving Warfarin therapy was completed. A tracking log was implemented to monitor lab results. New admissions/readmissions have signatures of 2 nurses reviewing admission orders. The Interdisciplinary Team reviewed physician's orders and lab tracking logs at the daily meeting Monday through Friday. The pharmacist will review the MARs (Medication Administration Records) monthly for physician orders and lab reports. The nurse consultant will monitor the Warfarin system monthly.</p> <p>This Federal tag relates to Complaint IN00152832.</p> <p>3.1-48(a)(3)</p>	F 329			