

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155289	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/13/2015
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NAME OF PROVIDER OR SUPPLIER COLONIAL OAKS HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 4725 S COLONIAL OAKS DR MARION, IN 46953
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F 0000 Bldg. 00	<p>This visit was for the Investigation of Complaint IN00179738.</p> <p>Complaint IN00179738- Substantiated. Federal/State deficiency related to allegation is cited at F333.</p> <p>Survey dates: August 12 and 13, 2015</p> <p>Facility number: 000186 Provider number: 155289 AIM number: 100266300</p> <p>Census bed type: SNF/NF: 92 Total: 92</p> <p>Census payor type: Medicare: 18 Medicaid: 59 Other: 15 Total: 92</p> <p>Sample: 5</p> <p>This deficiency reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p>	F 0000		
F 0333	483.25(m)(2)			

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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SS=D Bldg. 00	<p>RESIDENTS FREE OF SIGNIFICANT MED ERRORS</p> <p>The facility must ensure that residents are free of any significant medication errors. Based on interview and record review, the facility failed to administer an anti-coagulant medication as ordered by the physician, resulting in a significant medication error for 2 of 3 residents reviewed for anti-coagulant use. (Resident B and E)</p> <p>Findings include:</p> <p>1. The clinical record for Resident B was reviewed on 8/12/15 at 9:45 a.m. Diagnoses for the resident included, but were not limited to, arterial fibrillation, heart failure, hypertension, dementia and peripheral vascular disease. The significant change Minimum Data Set (MDS) assessment, dated 6/8/15, indicated Resident B was severely cognitively impaired.</p> <p>Review of the 7/24/15 laboratory value for the PT (Prothrombin Time) and INR (International Normalized Ratio), the PT level was 46.9 seconds. The normal range is between 9.0-12.0 seconds. The INR level was 4.23. The normal range is between 0.85-1.20. The laboratory report indicated the physician was notified and indicated to hold the current dose of Coumadin 7 mg for two days, and then</p>	F 0333	In Lieu of survey results, the facility respectfully request a paper review of the plan of correction. The facility is unable to correct the alleged deficient practice for residents B & E. All residents receiving Coumadin have the potential to be affected by the alleged deficient practice. DON/Unit Managers will review labs and Coumadin orders for the last 30 days to ensure no other resident has been affected by the alleged deficient practice. All labs and subsequent orders will be reviewed by two nurses to ensure complete accuracy. Nurses will be in-serviced by the DON regarding the check of labs and orders for coumadin. DON/Unit Managers will review all labs and the order transcription to ensure dosage and time of administration is correct. This will occur in the Departmental morning meeting ongoing. During the QA Committee meeting, Coumadin labs and the orders review will be discussed to ensure that there are no concerns. This will occur ongoing.	08/31/2015			

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	<p>restart at 5 mg, repeating the PT/INR in 4 days.</p> <p>Review of the July Medication Administration Record (MAR), Resident B received 7 mg of Coumadin on 7/22 and 7/23. The Coumadin dose was held on 7/24 and 7/25. The new order, dated 7/26/15, indicated to give 7 mg rather than the 5 mg dose ordered by the physician. Resident B received 7 mg of Coumadin on 7/26 and 7/27/15.</p> <p>Review of the 7/28/15 laboratory value for the PT and INR, the PT level was 64.1 seconds. The normal range is between 9.0-12.0 seconds. The INR level was 5.68. The normal range is between 0.85-1.20. The laboratory report indicated the physician was notified and indicated to hold the Coumadin and repeat the test in 2 days.</p> <p>Review of the 7/30/15 laboratory value for the PT and INR, indicated the PT level was 40.9 seconds. The normal range is between 9.0-12.0 seconds. The INR level was 3.72. The normal range is between 0.85-1.20. The laboratory report indicated the physician was notified and indicated to start Coumadin 3 mg daily.</p> <p>Review of a "Quick Memo", dated</p>			

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	<p>7/24/15, indicated to hold Coumadin for 2 days, then re-start Coumadin 5 mg daily and to re-check on 7/28/15.</p> <p>A current health care plan problem/need, dated 2/24/15, indicated a diagnosis of cardiovascular disease related to arterial fibrillation. The interventions included to give "Anticoagulant therapy as ordered and labs as ordered."</p> <p>A second health care plan problem/need, dated 8/6/15, indicated "risk for abnormal bruising and bleeding related the use of [missing word]." Interventions included, but were not limited to, "labs as ordered and to take medications as ordered."</p> <p>During an interview with the Director of Nursing (DON) and Unit Manager #1 on 8/13/15 at 11:20 a.m., the Unit Manager #1 indicated she transcribed the dose wrong when she put 7 mg rather than the 5mg that was ordered on 7/24/15. She indicated it was her handwriting on the "Quick Memo" and the medication error was her mistake. She indicated they had been unaware of the medication error.</p> <p>2. The closed clinical record for Resident E was reviewed on 8/13/15 at 10:08 a.m. Diagnoses for the resident included, but were not limited to, dementia, Alzheimer's disease, respiratory failure,</p>				

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	<p>aphasia, congestive heart failure and cerebrovascular accident. The significant change Minimum Data Set (MDS) assessment, dated 5/20/15, indicated Resident E was severely cognitively impaired.</p> <p>Review of the June Medication Administration Record (MAR), indicated Resident E received 7 mg of Coumadin 6/13, 6/15 and 6/16 at 8:00 a.m. The medication was held on 6/14/15. Resident E also received 7.5 mg of Coumadin on 7/16/15 at 8:00 p.m.</p> <p>Review of the 6/16/15 laboratory value for the PT and INR, the PT level was 10.9 seconds. The normal range is between 9.0-12.0 seconds. The INR level was 1.07. The normal range is between 0.85-1.20. The laboratory report indicated the physician was notified and indicated to increase the Coumadin dose to 7.5 mg.</p> <p>During an interview with Unit Manager #1, she indicated the nurse who put in the order of the Coumadin on 6/13/15, put it in as a "daily" medication. She indicated the computer then automatically put the medication due at 8:00 a.m. She indicated when the dose was changed on 6/16/15, the nurse put the order in as daily, but changed the time to be given at</p>			

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	<p>8:00 p.m. She indicated 3 different nurses saw the Coumadin dose scheduled at 8:00 a.m., but did not question the time. Resident E received 1 dose of Coumadin twice on 6/16/15. She indicated the medication was held on 6/14/15 because the nurse could not find it in the 8:00 p.m. drawer since it had been given at 8:00 a.m. days before.</p> <p>Review of a current facility policy revised 1/2011, provided by the DON on 8/13/15 at 11:50 a.m., titled "ADMINISTRATIVE PHYSICIAN'S ORDERS" indicated the following:</p> <p>"POLICY: To provided general guidelines when receiving, transcribing, notification, and care planning physician's orders.</p> <p>Performed By: Licensed Nursing 1. When receiving physician's orders by telephone: a. Enter the order into the resident's chart...</p> <p>...5. Following a physician visit, a licensed nurse will: *Check for any orders that require verification. The orders will be verified by the nurse and the instructions for the order will be completed.</p>			

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	<p>*Check the paper chart for any new written physician orders and transcribe them into the electronic medical record"</p> <p>This Federal tag relates to Complaint IN00179738.</p> <p>3.1-25(b)(9)</p>				