STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155656	A. BUILDING 00 B. WING	01/08/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CANTERBURY NURSING AND REHABILITATION CENTER	2827 NORTHGATE BLVD FORT WAYNE, IN 46835

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F000000	This visit was for the Investigation of Complaint IN00162064 and IN00162066. Complaint IN00162064- Substantiated. Deficiencies related to the allegations are cited at F282, F 309, and F329. Complaint IN00162066- Substantiated. Deficiencies related to the allegations are cited at F282. Survey dates: January 7, and 8, 2015 Facility number : 000275 Provider number: 155656 AIM number: 100290930 Survey team: Christine Fodrea, RN Census bed type: SNF/NF: 100 Total: 100 Census payor type: Medicare: 8 Medicaid: 77 Other: 15 Total: 100 Sample: 6	F000000	This Plan of Correction constitutes this facility's written allegation of compliance for the deficiencies cited. This submission of this plan of correction is not an admission of or agreement with the deficiencies or conclusions contained in the Department's inspection report. We respectfully request a desk review. We have included our re-education and monitoring tools for your convenience. Please feel free to contact Maya Kaczmarek at (260)580-6025 should you need additional information to assist you with your consideration.	

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

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	These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on January 9, 2015 by Randy Fry RN.			
F000282 SS=D	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. Based on interview and record review, the facility failed to follow physician orders for a medication for 1 of 3 residents reviewed for following physician orders in a sample of 6. (Resident #G) Findings include: Resident #G's record was reviewed 1-7-2015 at 3:10 PM. Resident #G's diagnoses included, but were not limited to, diabetes, high blood pressure, and Schizoaffective disorder. A physician's order dated 12-30-2014 indicated to begin giving Resident #G Coumadin (an anticoagulant) 4 mg	F000282	F 282: Services By Qualified Persons/Per Care Plan Corrective action for alleged deficient practice: 1. Resident #G reviewed and is receiving medications as ordered. Identification of others with potential to be affected by alleged deficient practice: 1. Residents receiving Coumadin are at risk. 100% audit completed on residents receiving Coumadin to ensure medications administered per order and therapeutic lab monitoring of PT/INR accurate. Systematic changes in place for alleged deficient practice: 1. Licensed nurses will be re-educated on policy regarding	02/02/2015

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	(milligrams) daily. A review of Medication Administration Record (MAR) dated 12-2014, indicated Resident #G received Coumadin 4 mg on 12-31-2014. A review of Resident #G's MAR dated 1-2015 indicated Coumadin 3 mg had been given in error on January 1, 2, 3, 4, 5, and 6. A review of Resident #G's lab results dated 12-30-2014 indicated the PT/INR results were 18.3 and 1.7 respectively. A review of Resident #G's lab results dated 1-7-2015 indicated the PT/INR results were 33.6 and 3.0 respectively. In an interview on 1-8-2015 at 2:14 PM, the Director of Nursing indicated the mistake was a transcription error during change over. She further indicated medications were to be given as ordered. This Federal tag relates to Complaint IN00162046, and IN00162066. 3.1-35(g)(2)		anticoagulant therapy and therapeutic monitoring of medications. Re-education will include monthly rewrite process. 2. Coumadin changes will be reviewed daily, Monday-Friday, in DCR (daily clinical review). How corrective action will be monitored to ensure alleged deficient practice does not reoccur: 1. Nurse managers will audit MARS (medication administration record) with each Coumadin medication change/new order and Coumadin systems audit Logs weekly x 6 months then monthly thereafter to ensure medications administered per order and therapeutic monitoring accurate. Identified trends will be reviewed in QA montly x three months and quarterly thereafter to determine further education and/or further monitoring needs. Identified non-compliance will result in one to one re-education up to and including termination. Any identified trends will be forwarded to the administrator for review and presented to QA to determine further education needs. Date of Compliance: February 2, 2015	
F000309	483.25			

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SS=D	PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Based on interview and record review, the facility failed to assess changes in resident status for 2 of 3 residents reviewed with changes in medical status in a sample of 6. (Resident #E and Resident #H) Findings include: 1. Resident #E's record was reviewed 1-8-2015 at 1:39 PM. Resident #E's diagnoses included, but were not limited to, high blood pressure, anemia, and blood clots. A Nurse's Note dated 12-13-2014 at 5:00 PM included: "Resident appears acting differently as stated in report all night and all day with chest pains." There were no Nursing Notes between 12-12-2014 at 10:48 PM through 12-13-2014 at 5:00 PM to indicate Resident #E had chest pain, the characteristics, or the level of the pain.	F000309	F 309: Provide Care/Services for Highest Well Being Corrective action for alleged deficient practice: 1. Resident #E no longer resides in facility. Resident #H has received an assess(ess)ment of current condition and non-symptomatic for further change in condition at this time. Identification of others with potential to be affected by alleged deficient practice: 1. Residents with change of condition/new onset of symptoms are at risk. 100% audit to be completed on residents for change in condition/new onset symptoms,changes in medical status. Systematic changes in place for alleged deficient practice: 1. Licensed nurses will be re-educated on policy regarding Interact III system and documentation requirements. How corrective action will be	02/02/2015

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	In an interview on 1-8-2015 at 2:46 PM, LPN #1 indicated Resident condition was to be assessed when it changed, and the change was to be documented. 2. Resident #H's record was reviewed 1-8-2015 at 2:37 PM. Resident #H's diagnoses included, but were not limited to, cerebellar ataxia (physical dysfunction related to brain lesions), restless leg syndrome, and Parkinson's Disease. A Nurse's Note dated 1-2-2015 at 5:00 PM indicated to obtain a urine specimen for analysis. There was no indication why the urine was being tested. A physician's order dated 1-2-2015 indicated to have the urine tested by analysis and culture and sensitivity due to the symptom of burning. A review of Nurse's Notes indicated the following: There were no Nurse's Notes dated 1-1-2015. There were no indications Resident #H was having any urinary symptoms on 1-2-2015, in either the 5:00 PM or 7:00 PM note, when the urine specimen was obtained, nor was there a description of the urine characteristics. There were no Nurse's notes dated between 1-2-2015 to 1-6-2015 for review. Nurse's notes dated 1-6-2015 at 1 PM indicated an order for		monitored to ensure alleged deficient practice does not reoccur: 1. Nurse managers will review residents with identified changes in condition/new onset symptoms for resident assessment of condition daily x 14 days; then weekly x 8 weeks; then 5 random monthly x 6 months. Identified trends will be reviewed in QA monthly x three months and quarterly thereafter to determine education and/ or further monitoring needs. Identified non-compliance will result in one to one re-education up to and including termination. Any identified trends will be forwarded to the administrator for review and presented to QA to determine further educational needs. Date of Compliance: February 2, 2015	

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	Pyridium (an analgesic antibiotic) 100 mg (milligrams) three times per day for 3 days. There was still no indication of urinary symptoms or of the characteristics of Resident #H's urine. In an interview on 1-8-2015 at 3:55 PM, the Director of Nursing indicated the staff should have been assessing and documenting urinary symptoms, if any, and of the characteristics of the urine between the time the urine was obtained for testing and the time the resident started on an antibiotic. This Federal tag relates to Complaint IN00162064. 3.1-37(a)			
F000329 SS=D	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			

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	should be reduced or discontinued; or any combinations of the reasons above. 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. Based on interview and record review, the facility failed to monitor for side effects of a medication sensitive to antibiotics while the resident was on antibiotics for 1 of 3 residents on antibiotics. (Resident #E) The facility further failed to ensure a resident was free of duplicate medication therapy for 1 of 3 residents reviewed on an antibiotic in a sample of 6. (Resident #E) Findings include: 1. Resident #E's record was reviewed 1-8-2015 at 1:39 PM. Resident #E's diagnoses included, but were not limited to, high blood pressure, anemia, and blood clots. A Physician's order dated 12-2-2014 indicated to give Resident #E Coumadin	F000329	F 329: Drug Regimen is Free From Unnecessary Drugs Corrective action for alleged non-compliance: Resident #E no longer resides in facility. Identification of others with potential to be affected by alleged deficient practice: Residents with new orders are at risk. 100% new order audit to be completed on residents to ensure order accurate follow-up and transcription. Systematic changes in place for alleged deficient practice: 1. Licensed nurses will receive re-education on order transcription process and lab tracking policy. 2. Licensed nurses will complete verification of written orders shift-to-shift by dating/initialling verification on order copies. How corrective action will be	02/02/2015

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	(an anticoagulant) 5 mg (milligrams) daily. A Physician's order dated 11-26-2014 indicated to give Resident #E Levaquin (an antibiotic) 500 mg daily for 10 days. A Physician's order dated 12-3-2014 indicated to give Resident #E Levaquin 500 mg daily for 10 days. A review of AMDA.com (American Medical Directors) on 1-8-2015 at 3:12 PM, indicated to check PT/INR levels every 3 days while the resident is on antibiotics. A review of Resident #E's Medication Administration Record (MAR) dated 12-2014, indicated there was an instruction under the medication box to check Resident #E's PT/INR every third day while the resident was on the antibiotic. A review of lab results dated 12-5-2014 indicated Resident #E's PT/INR was 14.1 and 1.3 respectively. There were no results for the dates of 12-9 and 12-12 available for review. In an interview on 1-8-2014 at 2:14 PM, the Director of Nursing indicated she had checked with the lab, and the PT/INR had		monitored to ensure alleged deficient practice does not reoccur: 1. Nurse managers will review new orders daily x 14 days; then weekly x 8 weeks; then (5 random) monthly x 6 months. Identified trends will be reviewed in QA monthly x three months and quarterly thereafter to determine education and/ or further monitoring needs. Identified non-compliance will result in one to one re-education up to and including termination. Any identified trends will be forwarded to the administrator for review and presented to QA to determine further educational needs. Date of Compliance: February 2, 2015	

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	not been drawn according to protocol. 2. A Physician's order dated 11-26-2014 indicated to give Resident #E Levaquin (an antibiotic) 500 mg daily for 10 days (with stop date being after the dose on 12-6). A Physician's order dated 12-3-2014 indicated to give Resident #E Levaquin 500 mg daily for 10 days (with start date being 12-3). The Nurse Practitioner's progress note dated 12-2-2014 indicated Resident #E had pneumonia and was on Levaquin. There was no indication the Nurse Practitioner was aware Resident #E was already on Levaquin, or the the prescription would be given as a double dose. A review of Resident #E's MAR dated 12-2014 indicated Levaquin 500 mg had been given twice on 12-3, 4, 5, and 6, 2014. A review of Nurse's Notes do not indicate the Nurse Practitioner was made aware of the double order. A review of fda.gov (Food and Drug Administration) indicated the accepted dosages of Levaquin for oral			

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	administration was 500 mg or 750 mg daily. In an interview on 1-8-2015 at 2:14 PM, the Director of Nursing indicated Resident #E should not have received a double dose of the antibiotic. This Federal tag relates to Complaint IN00162064. 3.1-48(b)(1)			