

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155728	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  04/12/2013
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NAME OF PROVIDER OR SUPPLIER  MANDERLEY HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 806 S BUCKEYE ST OSGOOD, IN 47037
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F000000	<p>This visit was for a Recertification and State Licensure survey.</p> <p>Survey dates: April 1, 2, 3, 4, 5, 11, and 12, 2013</p> <p>Facility number: 000493 Provider number: 155728 AIM number: 100291300</p> <p>Survey team: Diana Sidell RN, TC Gordon Tyree RN</p> <p>Census bed type: SNF/NF: 64 Total: 64</p> <p>Census payor type: Medicare: 8 Medicaid: 45 Other: 11 Total: 64</p> <p>This deficiency reflects state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality Review completed on April 18, 2013 by Brenda Meredith, R.N.</p>	F000000		

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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F000329 SS=D	<p>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 record review, observation and interview, the facility failed to ensure residents had care plans developed to monitor the side effects related to bruising and aspirin therapy. This affected 2 of 26 residents reviewed for care planning. (Residents #28 and 51)</p>	F000329	<p>1. Resident # 28 and #51's care plan has been modified to include monitor for side effects of aspirin therapy. See attachment #1 and # 2.2. All residents on anti-coagulant therapy have the potential to be affected. All current residents taking any type of anti - coagulant medications, charts have been reviewed and modified if necessary to include in</p>	04/29/2013	

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	<p>Findings include:</p> <p>1. Resident #28's record was reviewed on 4/11/13 at 4:15 p.m. The record indicated Resident #28 had diagnoses that included, but were not limited to, dementia, weakness, cerebral atrophy, non insulin dependent diabetes mellitus, high blood pressure, depression, urinary incontinence, failure to thrive, high blood fats, and low potassium levels.</p> <p>Current Physician's orders indicated an order for: "Aspirin 81 mg (milligrams), give 1 po (by mouth) qd (every day), anticoagulant" with a start date of 12/20/11.</p> <p>Hospice notes dated 3/26/13 at 2:25 p.m. indicated: "...Pt (patient) is lethargic &amp; sleeping during visit. She appears to be comfortable w/o pain...Sm[all] bruise noted to (R) hand. Spoke w (with)/facility nurse, [name of nurse], regarding pt's status...."</p> <p>On 4/2/13 at 11:16 a.m., Resident #28 was observed to have one nickel sized bruise on the outer part of the back of her left hand.</p> <p>During an interview on 4/11/13 at</p>		<p>the comprehensive Care Plan to monitor for signs and symptoms of adverse side effects of anti - coagulant medications.3. All new admits and all medication order changes containing any anti - coagulant medications will be communicated to MDS/ Care Plan department to be included in the care plan using the attached audit forms, attachment # 3 as they are recieved.4. Director of Nursing will monitor medication order changes and newly admitted residents medication orders daily for 4 weeks then weekly on going.5. Completion date of April 29, 2013.</p>		

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	<p>4:45 p.m., a family member indicated she had one small bruise on her hand recently but they (staff) didn't know what happened, they think she bumped her hand or rubbed it. Resident #28's hands were observed and had no bruising at this time. Resident #28 was observed constantly moving her hands around, would intertwine her fingers, then pull them apart, would run her left hand through her hair, then would rest it on the arm rest of the geri-chair she was seated in.</p> <p>No care plan was in the resident's record that addressed the aspirin therapy and side effects such as bruising.</p> <p>On 4/12/13 at 3:30 p.m., MDS (Minimum Data Set Assessment) Coordinator #1, indicated Resident #28 did not have a care plan for bruising related to the aspirin regimen, and that is something they usually care plan.</p> <p>2. Resident #51's record was reviewed on 4/12/13 at 10:31 a.m. The record indicated Resident #51 had diagnoses that included, but were not limited to, atrial fibrillation, hypertension, iron deficiency</p>						

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	<p>anemia, gastroesophageal reflux disorder, pneumonia, and kidney injury.</p> <p>Current Physician's orders indicated an order for "Aspirin 81 mg (milligrams) po (by mouth) qd (every day) for atrial fibrillation", with a start date of 11/28/12.</p> <p>Medication Administration Records for February, March, and April 2013 indicated the aspirin 81 mg was given every day in February and March, and April to date.</p> <p>On 4/3/13 at 10:51 a.m., a dime sized bruise was observed on the back of Resident 51's left hand. The resident said at that time that he bruises easily, especially if he has blood drawn.</p> <p>No care plan was in the resident's record that addressed the aspirin therapy and side effects such as bruising.</p> <p>On 4/12/13 at 3:30 p.m., MDS (Minimum Data Set Assessment) Coordinator #1, indicated Resident #51 did not have a care plan for bruising related to the aspirin regimen, and that is something they usually care plan.</p>						

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	<p>A policy and procedure, titled "Care Plan Development and Review Procedure", dated 8/2010, indicated, but was not limited to: "Purpose: To assure that a comprehensive care plan for each resident includes measurable objectives and timetables to meet the resident's medical and psychosocial needs. Policy: 1. An interdisciplinary team, in coordination with the resident and his/her family will develop a comprehensive care plan for each resident. 2. The comprehensive care plan has been designed to: Incorporate identified problem areas. Incorporate risk factors associated with identified problems...."</p> <p>3.1-48(a)(3)</p>				