

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155152	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  02/08/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  MONTICELLO HEALTHCARE	STREET ADDRESS, CITY, STATE, ZIP CODE 1120 N MAIN ST MONTICELLO, IN 47960
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000  Bldg. 00	<p>This visit was for the Investigation of Complaint IN00192802.</p> <p>This visit resulted in a Partially Extended Survey-Immediate Jeopardy.</p> <p>Complaint IN00192802-Substantiated. Federal/State deficiencies related to the allegation are cited at F282 and F329.</p> <p>Survey dates: February 4, 2016 Extended survey dates: February 5 &amp; 8, 2016</p> <p>Facility number: 000072 Provider number: 155152 AIM number: 100287440</p> <p>Census bed type: SNF: 19 SNF/NF: 75 Total: 94</p> <p>Census Payor type: Medicare: 19 Medicaid: 58 Other: 17 Total: 94</p> <p>Sample: 3 Extended sample 4</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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155152	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  02/08/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  MONTICELLO HEALTHCARE	STREET ADDRESS, CITY, STATE, ZIP CODE 1120 N MAIN ST MONTICELLO, IN 47960
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0282 SS=D Bldg. 00	<p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed by 26143, on February 16, 2016.</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 Physician's Orders, related to medications for 2 of 4 residents reviewed for Physician's Orders and Care Plans in an Extended Sample of 4. (Residents #F and #G)</p> <p>Findings include:</p> <p>1. Resident #F's record was reviewed on 02/05/16 at 1:30 p.m. The resident's diagnoses included, but were not limited to, atrial fibrillation and hypertension.</p>	F 0282	<p>F- 282-Services by Qualified Persons/Per Care Plan <b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</b></p> <ul style="list-style-type: none"> <li>·Resident F physician / family notified. Resident PT/INR checked on 02/05/2016, PT/INR levels checked in accordance with physician orders.</li> <li>·Resident G physician/family notified. The issue was of past non-compliance therefore PT/INR PT/INR levels checked in accordance with physician orders.</li> </ul>	02/21/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155152	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  02/08/2016
NAME OF PROVIDER OR SUPPLIER  MONTICELLO HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP CODE 1120 N MAIN ST MONTICELLO, IN 47960		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>The Admission Orders, indicated an order for warfarin (blood thinner) (Coumadin) 2.5 mg (milligram) tablet, take 1/2 tab (1.25 mg) daily.</p> <p>The Medication Administration Record (MAR), dated 01/13/16 through 02/05/16, indicated the resident's received warfarin 2.5 mg every evening on January 14, 15, 16, 17, and 18, 2015.</p> <p>A Coumadin Clinic Fax Form, dated 01/19/16, indicated the resident's INR (clotting time) was 3.0 (normal 0.72-1.11) (therapeutic INR 2.0-3.0), give Coumadin 1.25 mg on 01/19/16, and recheck the resident's INR on 01/20/16.</p> <p>The Coumadin 1.25 mg had not been transcribed onto the MAR on 01/19/16. The MAR indicated the resident had not received a dose of Coumadin on 01/19/16.</p> <p>A Coumadin Clinic Fax Form, dated 01/20/16, indicated the resident's INR was 5.5 (high). The order was to hold the Coumadin on January 20 and 21, 2016.</p> <p>During an interview on 02/05/16 at 2:25 p.m., the Director of Nursing (DoN) indicated the Admission Orders were to take a 1/2 tab of 2.5 mg of Coumadin to</p>		<p><b>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</b></p> <ul style="list-style-type: none"> <li>·All residents who were receive Coumadin(warfarin) (blood thinners) which require monitoring and PT's (pro-time) andINR (international normalized ratio) (laboratory blood clotting test) have thepotential to be affected by the alleged deficient practice.</li> <li>·Complete chart audit of all residentsreceiving Coumadin to ensure: <ul style="list-style-type: none"> <li>·Residents are on the accurate dose ofCoumadin per physicians order</li> <li>·Residents receiving Coumadin have laboratory orders for PT/INR</li> <li>·Resident care plans have been reviewedand updated.</li> <li>·All residents receiving Coumadin arebeing monitored for bleeding and/or bruising on a daily basis.</li> <li>·Physician notification of PT/INR resultsas well as any abnormal bleeding and or bruising.</li> <li>·Orders for anticoagulation side effectsare placed on every resident taking Coumadin.</li> <li>·All residents who receive Coumadin(warfarin) (blood thinners) which require monitoring and PT's (pro-time) andINR (international normalized ratio) (laboratory blood clotting test)</li> </ul> </li> </ul>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155152		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  02/08/2016	
NAME OF PROVIDER OR SUPPLIER  MONTICELLO HEALTHCARE				STREET ADDRESS, CITY, STATE, ZIP CODE 1120 N MAIN ST MONTICELLO, IN 47960			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>equal 1.25 mg. The DoN indicated the resident received 2.5 milligrams of Coumadin instead of the 1.25 mg.</p> <p>2. Resident #G's record was reviewed on 02/05/16 at 2:15 p.m. The resident's diagnoses included, but were not limited to, atrial fibrillation and left hip fracture.</p> <p>The Admission Orders, dated 01/27/16, indicated warfarin 5 mg daily, INR goal of 2-3.</p> <p>The MAR, dated 01/06/16 through 02/05/16, indicated no warfarin had been given on 01/27/16. The MAR indicated the order had not been transcribed on the Electronic MAR on 01/27/16.</p> <p>A Coumadin Clinic Fax Form, dated 01/28/16, indicated the resident's INR was 1.5, begin warfarin 7 mg, and recheck the INR on 01/29/16.</p> <p>The MAR, dated 01/06/16 through 02/05/16, indicated no warfarin had been administered on 01/28/16. The MAR indicated the order had not been transcribed on the Electronic MAR on 01/28/16.</p> <p>During an interview with the DoN on 02/05/16 at 4 p.m., she indicated the warfarin had not been administered as</p>		<p>have been identified and a daily audit by DNS and/or designee has been initiated to ensure observations are performed, labs are drawn, and timely orders being obtained and administered per plan of care.</p> <p><b>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? .</b></p> <ul style="list-style-type: none"> <li>-An in-service will be completed by the Director of Nursing and/or designee by February 8, 2016, or prior to returning to work for licensed nurses on the following: Coumadin (blood thinner) Policy and procedure review; Coumadin Policy and Lab Procedure review; Physician / responsible party notification; Admission/ Readmission policy review; Lab Tracking for PT/INR procedure review</li> <li>-New admissions / readmission will be verified / signed by two nurses to ensure accuracy and followed up on EMAR. <b>How the corrective action (s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</b></li> <li>-CQI audit tools "Admission/Readmission", will be utilized by the Director of Nursing and/or designee to monitor compliance. Audits will be completed weekly X 4 weeks,</li> </ul>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155152	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED  02/08/2016
NAME OF PROVIDER OR SUPPLIER  MONTICELLO HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP CODE 1120 N MAIN ST MONTICELLO, IN 47960		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 0329 SS=J Bldg. 00	<p>ordered on 01/27/16 and 01/28/16.</p> <p>This Federal Tag relates to complaint IN00192802.</p> <p>3.1-35(g)(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</p>		<p>monthly X 2 months, and quarterly thereafter for at least twoquarters.</p> <ul style="list-style-type: none"> <li>Results of Audit tools will be presented to the CQI Committee monthly to review for compliance and follow-up.</li> </ul> <p>Identified noncompliance may result in staff re-education and/or disciplinary action.</p> <ul style="list-style-type: none"> <li>If threshold of 95% is not achieved, an action plan will be developed to achieve desired threshold. Data will be submitted to the CQI committee for review and follow up.</li> </ul> <p><b>Compliance date: February 21, 2016</b></p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155152		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  02/08/2016	
NAME OF PROVIDER OR SUPPLIER  MONTICELLO HEALTHCARE				STREET ADDRESS, CITY, STATE, ZIP CODE 1120 N MAIN ST MONTICELLO, IN 47960			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>Based on record review and interview, the facility failed to monitor two residents (Residents #B and #C) who were receiving Coumadin (warfarin) (blood thinners), PT's (pro-time) and INR's (international normalized ratio) (laboratory blood clotting test) as ordered by the Physician. Resident #B was admitted into the hospital with the diagnoses of severe Coumadin toxicity and significant anemia related to the toxicity and received a blood transfusion and vitamin K (assist with blood clotting) and the other resident (Resident #C) required vitamin K treatment, for 2 of 3 residents reviewed for blood thinners in a total sample of 3. The facility also failed to monitor for signs and symptoms of bleeding related to the usage of blood thinners for 1 of 3 residents in a sample of 3 (Resident #C) and 2 of 4 in an extended sample of 4. (Residents #F and #G)</p> <p>The immediate jeopardy began on 01/15/16 when the facility failed to monitor a PT/INR on a resident (Resident #B) on Coumadin and Lovenox (also thins blood) as ordered by the Physician. This resulted in the Resident #B being admitted to the hospital with a diagnoses</p>	F 0329	<p>F- 329-Drug regimen is free from unnecessary drugs <b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</b></p> <ul style="list-style-type: none"> <li>·Resident B no longer resides at the facility</li> <li>·Resident C physician/family notified, resident PT/INR checked on 02/02/2016, PT/INR levels checked in accordance with physician orders.</li> <li>·Resident F physician / family notified. Resident PT/INR checked on 02/05/2016, PT/INR levels checked in accordance with physician orders</li> <li>·Resident G physician/family notified. The Issue was of past non-compliance therefore PT/INR levels checked in accordance with physician orders.</li> </ul> <p><b>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</b></p> <ul style="list-style-type: none"> <li>·All residents who were receive Coumadin (warfarin) (blood thinners) which require monitoring and PT's (pro-time) and INR (international normalized ratio) (laboratory blood clotting test) have the potential to be affected by the alleged deficient</li> </ul>	02/08/2016			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155152		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  02/08/2016	
NAME OF PROVIDER OR SUPPLIER  MONTICELLO HEALTHCARE				STREET ADDRESS, CITY, STATE, ZIP CODE 1120 N MAIN ST MONTICELLO, IN 47960			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>of severe Coumadin toxicity and significant anemia related to the toxicity and a PT of 128.6 and a critical INR of 11.69. Resident #B required a blood transfusion and Resident #C required Vitamin K for a critical PT of 129.6 and critical INR of 10.6. The Administrator and Director of Nursing were notified of the immediate jeopardy at 1:10 p.m. on 02/05/16. The immediate jeopardy was removed on 02/08/16, but noncompliance remained at the lower scope and severity level of no actual harm with potential for more than minimal harm that is not immediate jeopardy.</p> <p>Findings include:</p> <p>1. During the initial tour of the facility on 02/04/16 at 1:30 p.m., LPN Unit Manager #1 indicated Resident #B was in the hospital due to an abnormal PT and INR, and the resident had bruising prior to being transferred to the hospital.</p> <p>Resident #B's record was reviewed on 02/04/16 at 2:10 p.m. The resident's diagnoses included, but were not limited to atrial fibrillation, heart failure, and anemia. The resident had been admitted to the facility on 01/14/16.</p> <p>A care plan, dated 01/18/16, indicated the resident was at risk for</p>		<p>practice.</p> <ul style="list-style-type: none"> <li>·Complete chart audit of all residentsreceiving Coumadin to ensure: <ul style="list-style-type: none"> <li>·Residents are on the accurate dose ofCoumadin per physicians order</li> <li>·Residents receiving Coumadin havelaboratory orders for PT/INR</li> <li>·Resident care plans have been reviewedand updated.</li> <li>·All residents receiving Coumadin arebeing monitored for bleeding and/or bruising on a daily basis.</li> <li>·Physician notification of PT/INR resultsas well as any abnormal bleeding and or bruising or adverse side effects.</li> <li>·Orders for anticoagulation side effectsare placed on every resident taking Coumadin.</li> <li>·All residents who receive Coumadin(warfarin) (blood thinners) which require monitoring and PT's (pro-time) andINR (international normalized ratio) (laboratory blood clotting test) have beenidentified and a daily audit by DNS and/or designee has been initiated to ensure observations are performed, labs are drawn, and timely orders being obtained and administered per plan of care.</li> </ul> </li> </ul> <p><b>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?</b></p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155152	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED  02/08/2016
NAME OF PROVIDER OR SUPPLIER  MONTICELLO HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP CODE 1120 N MAIN ST MONTICELLO, IN 47960		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>abnormal/excessive bleeding due to the use of anticoagulant (blood thinner) medication, Lovenox and Coumadin. The interventions included to complete lab tests as ordered.</p> <p>The pre-admission PT/INR from the hospital, dated 01/14/16, indicated a PT of 16.2 (normal 8.4-12/9) and INR of 1.41 (normal 0.72-1.11) (therapeutic INR 2.0-3.0)</p> <p>The Hospital Admission Orders, dated 01/14/16, indicated orders for enoxaparin (Lovenox) 70 milligrams (mg) subcutaneous (injection) every 12 hours and warfarin 7.5 mg daily, follow up with an INR on 1/15/16 and, "dose accordingly". The orders indicated the resident received 5 mg of warfarin on 01/13/16 at 6 p.m.</p> <p>The facility's electronically transcribed Physician's Orders, dated 01/14/16, indicated an order for enoxaparin 70 mg every 12 hours and warfarin 7.5 mg every evening. There was no order written to recheck the INR on 01/15/16.</p> <p>The Medication Administration Record, dated 01/14/16 through 02/04/16, indicated the resident received the enoxaparin 70 mg every 12 hours on 01/14/16 through 02/01/16 and warfarin</p>		<p>·An in-service will be completed by the Director of Nursing and/or designee by February 8, 2016, or prior to returning to work for licensed nurses on the following: Coumadin (blood thinner) Policy and procedure review; Coumadin Policy and Lab Procedure review; Physician / responsible party notification; Admission/ Readmission policy review; Lab Tracking for PT/INR procedure review</p> <p>·The Director of nursing or designee will ensure that a flowsheet for every resident on Coumadin (warfarin) (blood thinners) which require monitoring and PT's (pro-time) and INR (international normalized ratio) (laboratory blood clotting test) resident is placed in the binder at the nurses cart.</p> <p>·The Director of Nursing Services and/or designee will complete a daily audit tool of the residents who receive Coumadin (warfarin) (blood thinners) which require monitoring and PT's (pro-time) and INR (international normalized ratio) (laboratory blood clotting test).</p> <p>·The Director of Nursing Services or Designee to be notified of a resident change of condition to the weekends; the Director of Nursing Services and / or Executive Director is notified as needed.</p> <p>·Noncompliance with physician orders and documentation related</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155152	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED  02/08/2016
NAME OF PROVIDER OR SUPPLIER  MONTICELLO HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP CODE 1120 N MAIN ST MONTICELLO, IN 47960		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>7.5 mg every evening on 01/15/16 through 02/01/16.</p> <p>A Physician's Progress Note, dated 01/24/16, indicated, "...continue Coumadin management by Coumadin Clinic (clinic which doses the warfarin by the PT/INR results)..."</p> <p>A Physician's Order, dated 01/29/16, indicated, "Please have INR level between 2-3..."</p> <p>There were no orders to indicate the facility received an order to monitor the INR after the Admission Order of 01/15/16. There were no orders to indicate the Coumadin Clinic had been notified of the need to manage the warfarin therapy.</p> <p>The Nurses' Progress Notes, dated 01/28/16 at 10:43 p.m., 01/29/16 at 6:54 p.m., 01/31/16 at 1:49 p.m., and 02/01/16 at 10:24 a.m., indicated the resident was complaining of pain in the right knee and leg area.</p> <p>The Nurses' Progress Notes, indicated: 02/01/16 at 3:31 p.m., "Call to (Physician Name)...re: therapy request of MRI for Right hip..."</p>		<p>to monitoring requirements for resident on Coumadin(warfarin) (blood thinners) which require monitoring and PT's (pro-time) andINR (international normalized ratio) (laboratory blood clotting test) result in reeducation and/ordisciplinary action.</p> <p><b>How the corrective action (s)will be monitored to ensure the deficient practice will not recur, i.e., whatquality assurance program will be put into place?</b></p> <ul style="list-style-type: none"> <li>·Daily Audit tool to be completed dailyby Director of Nursing services or designee</li> <li>·Coumadin CQI audit tool will be utilized by the Director of Nursing and/or designee to monitor compliance with facility policies and procedures.</li> <li>·Audits will be completed weekly X 4weeks, monthly X 5 months, and quarterly thereafter for at least two quarters.</li> <li>·Consulting pharmacist will reviewmedication sheet monthly for physician medication orders and appropriatelaboratory monitoring.</li> <li>·Pharmacist reports will be given to theDirector of Nursing Services for follow-up.</li> <li>·Results of these evaluation processeswill be presented to the CQI Committee monthly to review for compliance andfollow-up. Identified noncompliance may result in staff re-education and/ordisciplinary action.</li> <li>·If threshold of 100% is not</li> </ul>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155152	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  02/08/2016
NAME OF PROVIDER OR SUPPLIER  MONTICELLO HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP CODE 1120 N MAIN ST MONTICELLO, IN 47960		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>02/01/16 at 8:48 p.m., "New orders received...D/C Lovenox if INR greater than 2.0 when PT/INR is drawn on 02/04/16..."</p> <p>02/02/16 at 8:48 a.m., "During assessment of skin this morning, resident was noted to have a purple bruise on her right outer hip/thigh area and a purple bruise behind her right knee. Resident stated she did not know how it had happened..."</p> <p>02/02/16 at 8:55 a.m., "...c/o severe pain in right leg, thigh area, noted to have bruise on right thigh this a.m., Notified (Physician's Name)...order to transfer to ER for eval (evaluation) and treat..."</p> <p>A "New Skin Event", dated 02/02/16 at 9:09 a.m., indicated the bruise behind the right knee was 5.5 centimeters (cm) by 1.5 cm.</p> <p>A "New Skin Event", dated 02/02/16 at 9:06 a.m., indicated the bruise on the right outer hip/thigh was 23.5 cm by 8 cm.</p> <p>The Hospital Emergency Room Physician Progress Note, dated 02/02/16 at 9:59 a.m., indicated, "...Right hip pain Onset: 1 week Timing: constant...Quality: pain, bruising, Severity: moderate...PT</p>		<p>achieved, anaction plan will be developed to achieve desired threshold. Immediate follow up and corrective actioninitiated for any audit that falls out of range. Repeat CQI until 100%obtained. Data will be submitted to the CQI committee for review and follow up.</p> <p>·Nurse Consultant to Monitor Coumadinsystem monthly.</p> <p><b>Compliance date: 02/08/2016</b></p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155152		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  02/08/2016	
NAME OF PROVIDER OR SUPPLIER  MONTICELLO HEALTHCARE				STREET ADDRESS, CITY, STATE, ZIP CODE 1120 N MAIN ST MONTICELLO, IN 47960			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>(patient) states she noticed bruising to the area yesterday. She has had XR (x-ray)...no fx (fracture)...will do CT scan. I think likely she has had some remote trauma and with her being on Lovenox and Coumadin she has marked ecchymosis (bruising) and probably some bleeding... RBC (red blood cells) 2.38 (normal 3.8-5.7), hgb (hemoglobin) (carries oxygen in the blood) 7.2 (normal 12-15), HCT (hematacrit) (volume percentage of red blood cells) (Normal 35-49)... PT 128.6 sec (seconds) HI, INR 11.69 CRIT (critical)...CT lower extremity IMPRESSION: 1. Acute intramuscular hematomas expanding the gluteus minimus and vastus lateralis (hip and buttock area)...12:07 (p.m.)...blood transfusion is ready to be started...Impression and Plan 1. Acute intramuscular hematomas to right gluteus and right thigh 1. Sever coumadin toxicity 3. Small abdominal wall hematomas 4. Significant anemia secondary to #1, #2, and #3...Calls-Consults...she need to go to (Hospital Name) where orthopedics and general surgery is available just in case compartment syndrome develops (increased pressure in the muscles and nerves) or got worse...go ahead and give her Vitamin K...and blood transfusion..."</p> <p>A Hospital Admission History and</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155152		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  02/08/2016	
NAME OF PROVIDER OR SUPPLIER  MONTICELLO HEALTHCARE				STREET ADDRESS, CITY, STATE, ZIP CODE 1120 N MAIN ST MONTICELLO, IN 47960			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>Physical, dated 02/02/16 at 8:11 p.m., indicated, "...in the emergency department, workup showed that her INR was 11.69. Her last INR was on the day of discharge (01/14/16), which was 1.41. Her hemoglobin was also noticed dropping from 10.7 to 7.2...the patient was given 2 fresh frozen plasma and IV (intravenous) vitamin K...Assessment:...1. Right thigh hematoma, secondary to supratherapeutic INR 2. Supratherapeutic INR and the patient is also on full-dose Lovenox 3. Dehydration 4. Acute anemia, due to above...Plan: 1. At this point of time, considering the condition of the patient is guarded...my biggest concern is compartment syndrome...At this point in time, the thigh area is very tight, but peripheral circulation is intact...will closely monitor her hemoglobin...As far as acute anemia is concerned, which is secondary to right thigh hematoma, I will closely monitor her hemoglobin..."</p> <p>During an interview on 02/04/16 at 4:30 p.m., the Director of Nursing (DoN) indicated the PT/INR was not completed on 01/15/16 as ordered by the Physician. The DoN indicated the Admitting Nurse had not seen the order on the discharge instructions from the hospital. The DoN indicated an audit was completed on the admission 24 hours after admission and</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155152		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  02/08/2016	
NAME OF PROVIDER OR SUPPLIER  MONTICELLO HEALTHCARE				STREET ADDRESS, CITY, STATE, ZIP CODE 1120 N MAIN ST MONTICELLO, IN 47960			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>the second Nurse had also missed the PT/INR orders."</p> <p>2. Resident #C's record was reviewed on 02/05/16 at 8:30 a.m. The resident's diagnoses included, but were not limited to, post left hip fracture, stroke and congestive heart failure.</p> <p>A care plan, dated 01/15/16, indicated the resident was at risk for abnormal/excessive bleeding due to anticoagulant medication use. The interventions included, labs as ordered.</p> <p>A Physician's Order, dated 01/15/16, indicated to have the Coumadin Clinic manage the resident's warfarin usage.</p> <p>A Coumadin Clinic Fax Form, dated 01/27/16, indicated the resident's PT was 32 and INR was 2.8 and the order was to administer 2 mg of coumadin daily and recheck the INR on 02/01/16.</p> <p>A Physician's Order, dated 01/27/16, indicated to give warfarin 2 mg every evening and obtain a INR on 02/01/16.</p> <p>The Medication Administration Records, dated 01/2016 and 02/2016, indicated the resident received warfarin 2 mg at 5 p.m. on January 27-31, 2016 and February 1, 2016.</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155152	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  02/08/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  MONTICELLO HEALTHCARE	STREET ADDRESS, CITY, STATE, ZIP CODE 1120 N MAIN ST MONTICELLO, IN 47960
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>A Coumadin Clinic Fax Form, dated 02/01/16, indicated the PT/INR was missed on 02/01/16, Coumadin orders were for 2 mg daily, and to recheck the INR on 2/2/16 because the INR was missed on 02/01/16.</p> <p>A PT/INR result, dated 02/02/16, indicated the PT was 129.6, critical high and the INR was 10.6, critical high.</p> <p>A Coumadin Clinic Fax Form, dated 02/02/16, indicated to hold the Coumadin, give Vitamin K 2.5 mg, monitor for safety and bleeding, and to notify the Physician if any bleeding occurs.</p> <p>The Medication Administration Record, dated 02/2016, indicated the resident was not monitored for bleeding.</p> <p>There were no Nurses' Progress notes on 02/02/16 to indicate the resident had been monitored for signs of symptoms of bleeding.</p> <p>The Nurses' Progress Notes indicated:</p> <p>02/01/16 at 10:43 p.m. "...Abrasion to left lower back with scattered bruising observed..." (Resident with fall on 01/29/16)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155152	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  02/08/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  MONTICELLO HEALTHCARE	STREET ADDRESS, CITY, STATE, ZIP CODE 1120 N MAIN ST MONTICELLO, IN 47960
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>02/03/16 at 3:42 a.m., "...Drs (dressing) to left hip changed, moderate amount of sanguineous drainage (contains blood) noted..."</p> <p>02/03/16 at 2:28 p.m., "Drsg (dressing) changed to left hip, small amount bloody drng (drainage) on old drsg. surrounding skin bruised...hip is protruding and hard, possible hematoma...(Orthopedic Physician Name) notified..."</p> <p>02/04/16 at 9:50 a.m., indicated the Orthopedic Physician wanted to see the resident at the office.</p> <p>The Orthopedic Physician's Progress Note, dated 02/04/16, indicated the resident had a large hematoma on the left hip.</p> <p>During an interview on 02/05/16 at 9:55 a.m., the DoN indicated the facility had found in an audit the PT/INR lab draw was missed on 02/01/16. The DoN indicated she had not investigated why the PT/INR had not been obtained. The DoN indicated the order looked like it had been written but not put into the computer system to alert the Lab Company. The DoN indicated the error was found on 02/02/16 and thought it was just a transcription error on the date</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155152	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  02/08/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  MONTICELLO HEALTHCARE	STREET ADDRESS, CITY, STATE, ZIP CODE 1120 N MAIN ST MONTICELLO, IN 47960
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>and the lab was due on 02/02/16 not 02/01/16. The DoN indicated she had not seen the "missed" on the Coumadin Clinic Form. The DoN indicated there were no assessments of signs and symptoms of bleeding.</p> <p>3. Resident #F's record was reviewed on 02/05/16 at 1:30 p.m. The resident's diagnoses included, but were not limited to, atrial fibrillation and hypertension.</p> <p>The Admission Orders, indicated an order for warfarin (blood thinner) (Coumadin) 2.5 mg (milligram) tablet, take 1/2 tab (1.25 mg) daily.</p> <p>The Medication Administration Record (MAR), dated 01/13/16 through 02/05/16, indicated the resident's received warfarin 2.5 mg every evening on January 14, 15, 16, 17, and 18, 2015.</p> <p>A Coumadin Clinic Fax Form, dated 01/19/16, indicated the resident's INR (clotting time) was 3.0 (normal 0.72-1.11) (therapeutic INR 2.0-3.0), give Coumadin 1.25 mg on 01/19/16, and recheck the resident's INR on 01/20/16.</p> <p>The Coumadin 1.25 mg had not been transcribed onto the MAR on 01/19/16. The MAR indicated the resident had not received a dose of Coumadin on</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155152	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED  02/08/2016
NAME OF PROVIDER OR SUPPLIER  MONTICELLO HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP CODE 1120 N MAIN ST MONTICELLO, IN 47960		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>01/19/16.</p> <p>A Coumadin Clinic Fax Form, dated 01/20/16, indicated the resident's INR was 5.5 (high). The order was to hold the Coumadin on January 20 and 21, 2016.</p> <p>There was no documentation in the Nurses' Progress Notes or the MAR to indicate the resident had been monitored for signs and symptoms of bleeding.</p> <p>4. Resident #G's record was reviewed on 02/05/16 at 2:15 p.m. The resident's diagnoses included, but were not limited to, atrial fibrillation and left hip fracture.</p> <p>The Admission Orders, dated 01/27/16, indicated warfarin 5 mg daily, INR goal of 2-3.</p> <p>The MAR, dated 01/06/16 through 02/05/16, indicated no warfarin had been given on 01/27/16. The MAR indicated the order had not been transcribed on the Electronic MAR on 01/27/16.</p> <p>A Coumadin Clinic Fax Form, dated 01/28/16, indicated the resident's INR was 1.5, begin warfarin 7 mg, and recheck the INR on 01/29/16.</p> <p>The MAR, dated 01/06/16 through 02/05/16, indicated no warfarin had been</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155152	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  02/08/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  MONTICELLO HEALTHCARE	STREET ADDRESS, CITY, STATE, ZIP CODE 1120 N MAIN ST MONTICELLO, IN 47960
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>administered on 01/28/16. The MAR indicated the order had not been transcribed on the Electronic MAR on 01/28/16.</p> <p>There was no documentation in the Nurses' Progress Notes or the MAR to indicate the resident had been monitored for signs and symptoms of bleeding.</p> <p>During an interview with the DoN on 02/05/16 at 4 p.m., she indicated the Nurses' had not completed assessments for signs and symptoms of bleeding.</p> <p>A facility policy, dated 01/2016, titled, "Coumadin/Warfarin Monitoring", received from the DoN as the policy in place prior to the occurrence on 01/15/16, indicated, "...Orders of lab testing will be obtained per physician order...If there is a critical PT/INR result the physician will be notified immediately and an assessment of the resident documented in the medical record..."</p> <p>The immediate jeopardy that began on 01/15/16 was removed on 02/08/16 when the facility revised the procedure for obtaining and transcribing Physician's Orders and obtaining Physician's Orders for PT/INR's for residents on Coumadin and notification of the Coumadin Clinic of the orders. The facility initiated lab</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155152	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  02/08/2016
NAME OF PROVIDER OR SUPPLIER  MONTICELLO HEALTHCARE			STREET ADDRESS, CITY, STATE, ZIP CODE 1120 N MAIN ST MONTICELLO, IN 47960		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>tracking logs to ensure all PT/INR's were completed as ordered and inservices were completed on 28 of the 30 Nurses' and QMA's of the revised policy and procedures. The DoN indicated all other Nurses' and Nurses' just hired will be inserviced. Interview with the Nurses' indicated they were inserviced and knowledgeable of the revisions to the policy and procedures. Residents who had PT/INR's orders, had the lab completed and medication adjustments were initiated. A New Admission was reviewed, the resident was on Coumadin, orders were obtained for PT/INR's, and the Coumadin Clinic was notified, but the noncompliance remained at the lower scope and severity level of no actual harm with potential for more than minimal harm that is not immediate jeopardy.</p> <p>This Federal Tag relates to complaint IN00192802.</p> <p>3.1-48(a)(3) 3.1-48(a)(5)</p>				

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

PRINTED: 03/07/2016  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155152	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 02/08/2016
---	--	---	--

NAME OF PROVIDER OR SUPPLIER  MONTICELLO HEALTHCARE	STREET ADDRESS, CITY, STATE, ZIP CODE 1120 N MAIN ST MONTICELLO, IN 47960
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE