

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G079	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  06/29/2012
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NAME OF PROVIDER OR SUPPLIER  GOLDEN LIVING CENTER-NORTH WILLOW	STREET ADDRESS, CITY, STATE, ZIP CODE 2002 W 86TH ST INDIANAPOLIS, IN 46260
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W0000	<p>This visit was for a post-certification revisit (PCR) survey to the investigation of complaints #IN00107119 and #IN00106235 completed on 4/26/12.</p> <p>This visit was in conjunction with a PCR to the investigation of complaints #IN00108475 and #IN00107765 completed on 5/23/12. This visit resulted in an Immediate Jeopardy.</p> <p>This visit was in conjunction with the investigation of complaint #IN00109013.</p> <p>This visit was in conjunction with a PCR to the investigation of complaint #IN00103890 completed on 3/26/12.</p> <p>This visit was in conjunction with a PCR to the investigation of complaints #IN00101293 and #IN00102259 completed on 1/20/12.</p> <p>Dates of Survey: 6/25, 6/26, 6/27, 6/28 and 6/29/12</p> <p>Facility Number: 000622 Provider Number: 15G079 Aim Number: 100272170</p> <p>Surveyors: Paula Chika, Medical Surveyor III-Team</p>	W0000	<p><b><u>All corrective action completed by 7-29-12</u></b></p> <p><b><u>DISCLAIMER STATEMENT</u></b></p> <p>- <b>Submission of the plan of correction is not an admission that a deficiency exists or that they were cited correctly. This Plan of Correction is a desire to continuously enhance the quality of care and services provided to our residents and is submitted solely as a requirement of the provision of Federal &amp; State Law.</b></p> <p><b>"This Plan of Correction constitutes a written allegation of substantial compliance with Federal Medicare and Medicaid requirements."</b></p>	
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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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	<p>Leader Keith Briner, Medical Surveyor III Brenda Nunan RN, Public Health Nurse Surveyor III</p> <p>This deficiency also reflects state findings in accordance with 410 IAC 16.2. Quality Review completed 7/10/12 by Ruth Shackelford, Medical Surveyor III.</p>			

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W0331	<p>483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs.</p> <p>Based on interview and record review for 3 of 9 sampled clients (#1, #2 and #4) and for 2 additional clients (#10 and #11), the facility's nursing services failed to meet the nursing needs of the clients. The facility's nurses failed to obtain a timely swallow study, monitor a client's bowel movements to ensure staff reported accurate size and consistency, to develop nursing care plans when needed, to discontinue medications when ordered and to conduct quarterly nursing assessments of a client.</p> <p>Findings include:</p> <p>1. An Indiana Division of Disability and Rehabilitative Services report, dated 06/11/2012 at 6:30 p.m. was reviewed on 06/25/2012 at 1:45 p.m. The incident report indicated, "...Resident (client #10) was noted by nurse alert and awake while lying on her bed with a distended abdomen. Bowel sounds sluggish...sent to [hospital] ER (emergency room) for evaluation and treatment...."</p> <p>Client #10's record was reviewed on 06/26/2012 at 11:45 a.m. Diagnoses</p>	W0331	<p><b><u>W331 Nursing Services</u> The facility must provide clients with nursing services in accordance with their needs. <u>I</u> <u>Corrective Action for Cited Clients:</u> Resident 10 is deceased. An SBAR is written when a PRN medication is administered and notation is completed on the 24 hour report. PRN administration is followed up each shift, with a progress note written, until results are obtained. Re-training on the bowel protocol is completed. Staff training is completed with staff on the Bristol Scale. Nursing has been trained on documentation of appointments along with their outcome. CNA staff trained to document all issues on a BIR report, such as unusual sleepiness, for turning over to the nurse for assessment. A priority of resident risk is developed and residents ranked from high to low in terms of their risks. Nursing re-trained on carrying out an MD order timely and rewrite of orders reviewed. Nursing now aware that Program Director is providing assurance of accountability for their floor. <u>II Other Clients Potentially at Risk: All residents of North Willow are potentially at risk for this incorrect practice. <u>III</u> <u>Corrective Measures or</u></u></b></p>	07/29/2012			

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	<p>included, but were not limited to, constipation and ulcerative colitis.</p> <p>A "Nursing Progress Note," dated 05/23/2012 at 11:34 p.m., indicated, "...Mom (Milk of Magnesia) 30 cc (cubic centimeters) po (oral) given at 9 p.m. for lack of bm (bowel movement)...."</p> <p>A "Nursing Progress Note," dated 05/28/2012 at 2:38 p.m., indicated, "...Staff reported client has a distended belly. abd (abdomen) distended, bs (bowel sounds) x 4 quadrants present. No c/o (complaints) discomfort. Encouraged client to drink 240 cc glass of water and to sit on toilet for 15 minutes. No BM results. Administered 30 cc Mom po at 2:30 p.m. LBM (last bowel movement) 5/27/2012 LG (large) X 2...."</p> <p>A "Nursing Progress Note," dated 05/29/2012 at 12:12 a.m., indicated, "...No bm noted this shift...."</p> <p>A "Nursing Progress Note," dated 05/29/2012 at 7:17 a.m., indicated, "...NO BM THRU (through) THE NIGHT...." Bowel elimination was not addressed in nursing notes again until 06/08/2012.</p> <p>A "Nursing Progress Note," dated 06/08/2012 at 10:20 a.m., indicated, "...Abdomen firm and distended. MOM</p>		<p><b>Systemic Changes:</b> SBARs are reviewed as part of morning meeting by Nursing Management, Program Directors and ED or Designees. The Bristol Scale is used to aid in documentation of bowel movements. Medical appointment scheduler updates calendar of appointments daily. A copy of outside consults is given to the Receptionist to aid in adding necessary appointments to the calendar in a timely manner. Issues with scheduling will be reported by the team to the Program Director for follow up. Nursing trained that a BIR will be generated for changes in condition and when given a BIR for this reason to assess resident for further needed action. These assessments and any action must be documented in progress notes. Those residents deemed at high risk have a plan which has been trained with their staff to assist in giving adequate care to that resident addressing their particular risk areas. (all residents will have a risk plan in place that is trained with their staff no later than 12-1-12 due to detailed nature of risk plans). Nursing reminded to complete quarterly reports timely. Program Directors assure that reports are timely for their floor.<u>IV</u></p> <p><b>Monitoring Corrective Measures:</b> Nursing Management assures follow up completion to PRN administration as to each shift documenting until results are</p>				

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	<p>30 cc administered...."</p> <p>A "Nursing Progress Note," dated 06/08/2012 at 9:21 p.m., indicated, "...Mom 30 cc po given at 8:00 p.m. for lack of bm...." Bowel elimination was not addressed in nursing notes again until 06/11/2012.</p> <p>A "Nursing Progress Note," dated 06/11/2012 at 1:00 p.m. (identified as "late entry"), indicated, "...Upon entering clients room for oral tx (treatment), noticed client's distended abdomen. client resting back in her bed with eyes closed...bs (bowel sounds x 4 quadrants present/sluggish. no c/o (complaint) discomfort observed when touching abd (abdomen)...Notified Md (medical doctor)...Tx (treated) client with prn (as needed) MOM 30 cc po...."</p> <p>A "Nursing Progress Note," dated 06/11/2012 at 11:45 p.m., indicated, "...Client was admitted to [hospital] tonight...."</p> <p>The Physician's orders, dated 06/01/2012-06/30/2012, indicated, "...Check BM (bowel movement) per shift as nursing measure TID (three times daily)...IF NO BM IN 3 DAYS DO PHYSICAL ASSESSMENT OF CLIENT. ASSESS FOR BOWEL</p>		<p>obtained. Each Program Director is in charge of their floor including nursing oversight for all but highly clinical issues such as medication errors. Issues in scheduling experienced by the Program Director will be reported to ED/DNS for assistance in executing. BIR reports are reviewed daily as part of the morning meeting process and by the Program Director/Designee for follow up issues. Resident risk plan will be reviewed as part of the quarterly and annual ISP process by the team with the QMRP as the lead. QA has approved the format for risk plans. Continued late reports are dealt with using disciplinary action when needed.</p>				

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	<p>SOUNDS X 4 QUADRANTS. LISTEN FOR AT LEAST 1 MINUTE...GIVE MILK OF MAGNESIA 30 CC (cubic centimeters) PO (oral) OR G-TUBE (tube that has surgically been inserted into stomach for nutritional and/or medication) QD (every day) PRN (as needed). IF NO BM IN 12 HOURS FOLLOWING THE MOM (Milk of Magnesia), THEN ADMINISTER FLEET ENEMA, NOTIFY PHYSICIAN IMMEDIATELY IF POOR OR NO BM RESULTS AFTER FLEETS...."</p> <p>A bowel elimination record, dated 06/2012, indicated client #10 had medium size bowel movements daily from 06/01/2012-06/07/2012. No bowel movement was documented on 06/08/2012. A large bowel movement was documented on 06/09/2012. Medium bowel movements were documented on 06/11/2012. The bowel elimination record did not include documentation of consistency of bowel movements. The record indicated client #10 was sent to the emergency room to evaluate abdominal distention on 06/11/2012.</p> <p>The Medication Administration Record (MAR), dated 06/01/2012-06/30/2012, indicated Milk of Magnesia was administered to client #10 on 06/08/2012 at 8:35 a.m. and 06/11/2012 at 1:20 p.m.</p>				

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	<p>The record indicated, "...Noted distended Abd (abdomen). BS (bowel sound x 4 present (with "sluggish" written above entry). Tx'd (treated) (symbol for with) PRN MOM (as needed Milk of Magnesia) 30 cc @ (at) 1:20 p.m. The record did not include documentation to indicate efficacy of the prn medication for either date that it was administered.</p> <p>A hospital "History and Physical," dated 06/12/2012, indicated, "...admitted to the hospital on June 11, 2012, with a small bowel obstruction....Her abdomen is severely distended, firm and rock hard...."</p> <p>A CT (computed tomography used for medical imaging) of the abdomen and pelvis, dated 06/11/2012, indicated, "...Fecal impaction with a massive amount of stool within the rectum and sigmoid colon...."</p> <p>A hospital "Discharge Summary," dated 06/12/2012 at 5:55 p.m., indicated, "...The patient had a bowel obstruction secondary to retained stool...There was a massive amount of stool within the rectum and sigmoid colon...She was given enemas upon admission in attempts to clean out her colon. These enemas were met with mild results. The enemas were continuing during the day when in the mid afternoon, the attending nurse did</p>						

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	<p>notice that the abdomen became suddenly more distended than what was already present...the patient was noted to be relatively unresponsive but to have an abdomen that was markedly distended with absence of bowel tones...The physicians at that time had an opportunity to speak with the family and it was determined that no heroic measures should be undertaken to treat the patient...The risk that the patient would not be able to survive due to fact that she is likely in some sort of a potential septic shock syndrome (dangerously low blood pressure) induced by the presence of some ischemic colitis (injury of the large intestine resulting from insufficient blood supply), secondary to the abdominal distension and/or hastened by potential perforation of the intestine brought on by the colonic distention and introduction of enema is unclear. The patient was the kept comfortable and she passed away with the time of death being June 12, 2012 at 1755 (5:55 p.m.) hours...FINAL DIAGNOSES: 1. Probable septic shock syndrome. 2. Probable ischemic colitis secondary to bowel obstruction. 3. Bowel obstruction of the large colon secondary to severe hypomotility (deficient bowel motility) and fecal impaction...."</p> <p>A "Certificate of Death," dated</p>			

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	<p>06/12/2012 at 5:54 p.m., indicated, "...Cause of Death...SEPTICEMIC SHOCK...ISCHEMIC BOWEL...MEGACOLON WITH OBSTRUCTION...."</p> <p>During an interview on 06/27/2012 at 1:45 p.m., LPN #1 indicated bowel elimination was tracked by the CNAs (Certified Nurse Aides) and recorded on the BM record. The LPN indicated she reviewed the record to determine if the client had a bowel movement. LPN #1 indicated she did not do regular assessments of client #10's abdomen to check for distention. She indicated she checked the resident if there was no bowel movement recorded on the BM record or if she noticed or a CNA reported the client had something wrong. She indicated client #10 was given prn medication for bowel elimination on 05/28/12. LPN #1 indicated she observed the client with a distended abdomen on 06/11/2012 and notified the physician. She indicated the physician instructed her to send client #10 to the hospital for an evaluation.</p> <p>During an interview on 06/27/2012 at 2:00 p.m. CNA #11 indicated client #10 had bowel movements in incontinence briefs. She stated client #10 "had endless BM's." CNA #11 indicated client #10 had</p>						

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	<p>fecal smearing in her incontinence briefs and had to be wiped repeatedly to cleanse the BM from the rectal area. She indicated client #10 also used to toilet for elimination.</p> <p>During an interview on 06/27/2012 at 2:10 p.m., CNA #10 stated, "[Client #10] never had formed stool the entire 3-4 years I worked with her." She indicated she measured bowel movements by the number of wipes required to cleanse the stool from her buttocks.</p> <p>During an interview on 6/27/2012 at 2:25 p.m., the Director of Nursing (DoN) indicated client #10 was eating dinner in the dining room when LPN #1 informed her the physician recommended client #1 be transported to the hospital for evaluation of abdominal distention. The DoN indicated staff were in-serviced after client #10 died in regard to measuring the amount of bowel elimination. The DoN indicated bowel movements were only monitored in terms of size, but not consistency.</p> <p>During an interview on 06/27/2012 at 2:25 p.m., the Administrator stated the Bristol Stool Scale (a medical chart used to classify the form of human feces into seven categories) was "too complicated for staff to interpret." She indicated staff</p>				

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	<p>were trained to monitor the size of bowel elimination after client #10 died.</p> <p>2. Client #4's record was reviewed on 06/27/2012 at 4:45 p.m. A " Fax Note" to the physician, dated 01/30/2012 indicated the Speech Therapist recommended a video swallow evaluation.</p> <p>A Physician's Order, dated 02/08/2012 indicated, "...[Hospital] needs a sign (sic) order from MD (medical doctor) to have a repeat VFSS (video fluoroscopic swallowing study that allows visualization of where food goes when it is swallowed) to R/O (rule out) aspiration D/T (due to) increase in function of Dysphasia...."</p> <p>A Physician's Order, dated 03/30/2012, indicated, "...May have video swallow study to assess pharyngeal phase of swallow and assess for silent aspiration...."</p> <p>A Physician's Order, dated 04/30/2012, indicated, "...May have a video swallow study to assess pharyngeal phase of swallow and to assess for silent aspiration D/T dysphasia...."</p> <p>The record indicated a videofluoroscopic swallow evaluation was completed on 05/01/2012. the VFSS results report,</p>						

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	<p>dated 05/01/2012 indicated client #4's diet could be advanced from g-tube feedings to receive an oral diet of pureed food and nectar thick liquids.</p> <p>A Physician's order, dated 06/23/2012, indicated, "...D/C (discontinue) TF (tube feeding) orders. New order: Start 1 can Jevity 1.5 via enteral (g-tube) feed if resident eats &lt; (less than) 50 % meals. Give 1 can Jevity 1.5 enteral feed at HS (bedtime)...."</p> <p>During an interview on 06/27/2012 at 3:55 p.m., the Assistant Director of Nursing and Director of Nursing indicated the recommendation for repeating the swallow study should have been implemented when requested.</p> <p>3. The facility's reportable incident reports and/or investigations were reviewed on 6/25/12 at 1:54 PM. The facility's 6/14/12 reportable incident report indicated "Client (client #11) became unresponsive. CRP (sic) cardiopulmonary resuscitation) administered. 911 called. Client was taken to the emergency room."</p> <p>The facility's 6/17/12 reportable incident report indicated "Resident (client #11) complained of abdominal discomfort at approx. (approximately) 11:00 AM (sic)</p>						

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	Nursing assessed, and resident suddenly became unresponsive with no palpable pulse. Nursing initiated CPR and 911 was phoned. EMS (Emergency Management Services) arrived and continued CPR, and transported to hospital at 11:15 AM. Resident expired at hospital at 5:46 PM on 6-17-12. Hospital reports cardiac arrest, and 'abdominal catastrophe.'" The 6/17/12 reportable incident report indicated client #11's death was a "Sudden death." An attached 6/17/12 witness statement by CNA (Certified Nurse Aide) #7 indicated "...Yesterday, it just seemed like she was sleepy the whole day...She did not ask for a pop or anything." An attached 6/17/12 witness statement by RN #1 indicated client #11 had been pointing to her stomach. A 6/19/12 witness statement by CNA #9 indicated client #11 had been complaining of being dizzy prior to 6/17/12. CNA #9 indicated client #11 "...was real thirsty-sounded gurgly...." An attached 6/19/12 witness statement by LPN #2 indicated client #11 had 3 similar episodes within the past 2 years. LPN #2's witness statement indicated they would send the client to the hospital and the client would be returned to the facility. LPN #2's witness statement indicated client #11 was returned with a seizure diagnosis after one episode. LPN #2's witness statement indicated				

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	<p>"Paramedics said this was definitely not a seizure."</p> <p>LPN #3's 6/18/12 witness statement indicated client #11 had "some incidents previous-but no MI's (myocardial infarctions-heart attack)...." LPN #3's witness statement indicated one time, a CNA thought client #11 was dead when client #11 had a similar episode and LPN #3 had to start chest compressions. LPN #3's witness statement indicated "...Found she had a blocked left carotid. Had nothing to do with her heart...."</p> <p>Attached hospital documents with the above mentioned witness statements indicated the following:</p> <p>-9/11/08 Discharge Summary indicated client #11 "...who was attending workshop and apparently was found by the aids (sic) at the workshop on the floor in the restroom. They were, at that time, noticing that she was unresponsive and had an ashen color. They called 911. The patient was not arousable at that time and there was concern that she may have had some devastating event...." The 9/11/08 Discharge Summary indicated client #11 was admitted to the hospital but remained stable during admission with no health concerns noted.</p>						

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	<p>-9/24/08 Carotid Sonogram indicated "Both Carotid bulbs appear free of plaque or intimal thickening. Peak systolic velocity in the right carotid bulb is 80 cm/sec (centimeter per second), in the left 101 cm/sec. Peak systolic velocity ratios and waveforms are normal. No flow is detected in the left vertebral artery. There is normal antegrade flow in the right vertebral artery. Impression: Normal bilateral carotid bulbs; no flow detected left vertebral artery." The 9/24/08 sonogram indicated "...FULL RESULT: Indication: Syncope (loss of consciousness-fainting)...."</p> <p>-Client #11 was seen by a cardiologist on 10/10/08. The 10/10/08 Cardiology sheet indicated a diagnosis of "Arrhythmia Symptoms Syncope/Pre-syncope." The Cardiology sheet indicated a 2 D doppler echocardiogram was ordered.</p> <p>-2/1/10 Discharge Summary indicated on 1/31/10, client #11 was "...noted to be sitting on a toilet at the extended care facility and was unresponsive to the staff. Consequently, the nursing staff thought that they had a patient who was pulseless and did initiate some chest compressions just to be precautions. They called 9-1-1, and the patient was sent over to the emergency room for a full evaluation...." The discharge summary indicated</p>						

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	<p>"...Discharge Diagnoses: 1. Period of unresponsiveness, etiology undefined..."</p> <p>-2/1/10 Consultation note (neurology) indicated client #11 was evaluated for seizures. The note indicated client #11 was on medication for seizures. The note indicated "...This certainly sounds more like a syncopal episode, possibly vasovagal...Recommendations: I do not think this is a seizure. I believe it is okay for her to be discharged...."</p> <p>-3/4/10 Client #11 was again seen in the ER for a syncope event. The 3/4/10 Discharge/Transfer Form indicated client #11 was diagnosed as having seizures.</p> <p>Client #11's 6/17/12 Critical Care H&amp;P (history and physical) indicated client #11 "...reportedly was walking today in the hallway and suddenly collapsed on the floor and became unresponsive. The pulse was lost according to the extended care facility and she was started on CPR until the ambulance arrived. She was intubated in the field and she had a total of 25 minutes of CPR after she arrived in the emergency room at [name of hospital]. According to the report, she has been having dizziness the last couple of days but no seizure or chest pain. Upon arrival to the emergency room, she was hypertensive...Abdomen is extremely</p>						

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	<p>hard to palpation...."</p> <p>Client #11's hospital records were reviewed on 6/27/12 at 1:10 PM. Client #11's Death Summary indicated "...Discharge Diagnoses:</p> <ol style="list-style-type: none"> <li>1. Cardiac arrest.</li> <li>2. Acute respiratory failure</li> <li>3. Abdominal catastrophe...."</li> </ol> <p>Client #11's record was reviewed on 6/26/12 at 11:44 AM. Client #11's June 2012 Nurses Notes indicated the following:</p> <p>-6/6/12 10:53 PM "Client urine is dark in color MD (medical doctor) was faxed awaiting orders."</p> <p>-6/7/12 7:19 AM "Awaiting reply from MD concerning dark urine."</p> <p>-6/7/12 3:42 PM "Client received a new order to obtain UA (urine analysis) C&amp;S (culture and sensitivity)."</p> <p>-6/8/12 "UA results faxed to MD UA is clear."</p> <p>-6/17/12 6:45 AM "Client easy to arouse, appears to have rested well. No complaints."</p> <p>Client #11's 6/12 nurses notes did not</p>						

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	<p>indicate the facility's nurses were informed of and/or documented client #11's complaints of dizziness and/or increased sleeping.</p> <p>Client #11's 5/23/12 physician's orders indicated client C's diagnoses included, but were not limited to, Secondary Hypertension, Acute Gastric Ulcer with Hemorrhage and constipation. Client #11's 5/23/12 orders did not indicate client #11 had a diagnosis of Syncope. The 5/23/12 physician's order indicated client #11 received Amlodipine Besylate 5 milligrams daily for blood pressure. The physician's order indicated the medication was to be held if the client's systolic blood pressure (top number) was less than 100. The 5/23/12 physician's order indicated the medication was started on 10/1/11. The 5/23/12 physician's order indicated "...BP (blood pressure) as a nursing measure-Three times a week Specific days of week: Mon Wed Sat..." The 5/23/12 physician's order indicated the nursing measure in regard to client #11's BP was started 4/28/10.</p> <p>Client #11's 10/11/11 Individual Support Plan (ISP) and/or record indicated client #11 did not have a nursing care/risk plan for Hypertension, Syncope and/or ulcers.</p> <p>Interview with the Director of Nursing</p>			

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	<p>(DON) on 6/27/12 at 10:00 AM indicated the facility was told client #11 died of a cardiac arrest. The DON stated client #11's physician was told client #11's abdomen was "full of air" and did not have a bowel obstruction. The DON indicated CPR had been performed on client #11 in the past for similar episodes of not having a pulse and/or unconsciousness. The DON indicated the facility was not aware of any heart issues with the client. The DON indicated the client had more episodes of unconsciousness since 2008. The DON indicated she did not think client #11 had been re-evaluated by a cardiologist since 2008 unless it was done at one of the hospital visits. The DON stated client #11 would have had to have "medical clearance (cardiac work up) prior to the client's surgery in 9/11 to repair a fracture.</p> <p>Interview with LPN #3 on 6/27/12 at 10:55 AM indicated client #11 had several episodes of being unresponsive. LPN #3 indicated client #2 would be sent over to the emergency room and they would send her back saying she had a seizure or nothing was wrong with her. When asked when client #11 had one of those episodes, LPN #2 stated "2/11 or 3/11." LPN #3 stated client #11 did not have a history of heart disease but did have a "blocked carotid total occlusion."</p>				

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	<p>LPN #3 indicated she thought client #11's guardian and doctor decided client #11 was not a good candidate for surgery. LPN #3 indicated she was not aware if client #11 had been reassessed by a cardiologist since 11/08. LPN #3 indicated the Cardiologist did not find anything wrong with client #11's heart in 11/08. LPN #3 indicated client #11 was fine and did not have any health concerns prior to her death. LPN #3 indicated the nursing staff monitored client #11's BP three days a week. LPN #3 indicated client #11 did not have a written nursing care plan for hypertension. LPN #3 indicated nursing staff were to hold client #11's BP medication if her systolic reading was less than 100.</p> <p>4. Client #1's record was reviewed on 6/27/12 at 8:02 AM. Client #1's 5/12 signed physician's orders indicated client #1 received Bisacodyl 10 milligrams suppository as needed for constipation.</p> <p>Client #1's March 2012 pharmacy review indicated "This resident is taking an over the counter medication that is not covered by Indiana Medicaid. Please consider discontinuing or switching to a covered alternative...2) Bisacodyl supp (suppository) PRN (as needed)...." Client #1's doctor responded to the pharmacist recommendation at the bottom of the</p>			

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	<p>March 2012 pharmacy review page on 3/22/12. Client #1's doctor wrote an order to discontinue the Bisacodyl.</p> <p>Interview with Program Director #1 on 6/27/12 at 9:15 AM indicated she was not sure why client #1's Bisacodyl was still on the client's 5/12 MAR (medication administration record). PD #1 indicated the client's doctor discontinued the medication on 3/22/12.</p> <p>Interview with the DON on 6/27/12 at 10:00 AM indicated client #1's Bisacodyl should have been discontinued/removed from the physician's orders. The DON stated she had a nurse just "spend 3 days to clean up orders." The DON indicated client #1's signed 5/12 physician's order indicated client #1's doctor had signed the orders with the Bisacodyl PRN on it, but the medication should actually still be discontinued as it was on the order by mistake.</p> <p>5. Client #2's record was reviewed on 6/26/12 at 4:25 PM. Client #2's 5/12 physician's orders indicated client #2's diagnoses included, but were not limited to, Anemia, Acute Venous Embolism, Neuropathy, Thrombosis, Epilepsy and Neurogenic Bladder.</p> <p>Client #2's record indicated client #2 had</p>						

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	<p>2 nurse quarterly examinations dated 8/31/11 and 1/27/12 completed for one year.</p> <p>Interview with LPN #1 on 6/27/12 at 2:22 PM indicated client #2 should have 4 nurse quarterly reviews in his chart. LPN #1 indicated she was not able to locate any additional quarterly reviews for client #2. LPN #1 stated client #2 was due a nurse quarterly review on 5/2/12, but she "missed him."</p> <p>This federal tag relates to complaints #IN00107119 and #IN00106235.</p> <p>This deficiency was cited on 4/26/12. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>3.1-17(a)</p>						